

# **GMS STATEMENT OF FINANCIAL ENTITLEMENTS**

## **TABLE OF CONTENTS**

### **1. INTRODUCTION**

#### ***PART 1 GLOBAL SUM AND MINIMUM PRACTICE INCOME GUARANTEE***

### **2. GLOBAL SUM PAYMENTS**

**Calculation of a contractor's first Initial Global Sum Monthly Payment**  
**Calculation of Adjusted Global Sum Monthly Payments**  
**First Payable Global Sum Monthly Payment**  
**Revision of Payable Global Sum Monthly Payments**  
**Conditions attached to Payable Global Sum Monthly Payments**  
**Contractor Population Index**

### **3. MINIMUM PRACTICE INCOME GUARANTEE**

**Calculation of Global Sum Equivalent**  
**Calculation of Correction Factor Monthly Payments**  
**Review and revision of Correction Factor Monthly Payments in respect of  
financial year 2011/12 and financial years thereafter**  
**Practice mergers or splits**  
**Conditions attached to payment of Correction Factor Monthly Payments**

#### ***PART 2 QUALITY AND OUTCOMES FRAMEWORK***

### **4. QUALITY AND OUTCOMES FRAMEWORK: GENERAL**

**Types of payments in relation to the QOF**  
**The four principal domains of the QOF**  
**Calculation of points in the clinical domain**  
**Calculation of points in the organisational domain**  
**Calculation of points in the patient experience domain**  
**Calculation of points in the additional services domain**

### **5. ASPIRATION PAYMENTS**

**Calculation of Monthly Aspiration Payments: general**  
**Calculation of Monthly Aspiration Payments: the 70% method**

**Calculation of Monthly Aspiration Payments: the Aspiration Points Total method**

**Payment arrangements for Monthly Aspiration Payments**

**Conditions attached to Monthly Aspiration Payments**

## **6. ACHIEVEMENT PAYMENTS**

**Basis of Achievement Payments**

**Returns in respect of Achievement Payments**

**Calculation of Achievement Payments**

**Recovery where Aspiration Payments have been too high**

**Accounting arrangements and due date for Achievement Payments**

**Conditions attached to Achievement Payments**

### ***PART 3***

### ***DIRECTED ENHANCED SERVICES***

## **7. NOT ALLOCATED**

## **8. CHILDHOOD IMMUNISATIONS SCHEME**

**Childhood Immunisation Scheme plans**

**Target payments in respect of two-year-olds**

**Calculation of Quarterly Two-Year-Olds Immunisation Payment**

**Conditions attached to Quarterly Two-Year-Olds Immunisation Payments**

**Target payments in respect of five-year-olds**

**Calculation of Quarterly Five-Year-Olds Immunisation Payment**

**Conditions attached to Quarterly Five-Year-Olds Immunisation Payments**

### ***PART 4***

### ***PAYMENTS FOR SPECIFIC PURPOSES***

## **8A. PNEUMOCOCCAL VACCINATION AND HIB/MENC BOOSTER VACCINATION**

**Payment for administration of PCV vaccinations and Hib/MenC vaccinations as part of the routine childhood immunisation schedule**

**Payment for administration of PCV vaccinations other than as part of the routine childhood immunisation schedule**

**Children at increased risk of pneumococcal infection**

**Children over the age of 13 months but under 5 years who have previously had invasive pneumococcal disease**

**Children with an unknown or incomplete vaccination status**

**Eligibility for payment**

**Claims for payment**

**Conditions attached to payment**

## **9. PAYMENTS FOR LOCUMS COVERING MATERNITY, PATERNITY AND ADOPTION LEAVE**

**Entitlement to payments for covering ordinary maternity, paternity and ordinary adoption leave**  
**Ceilings on the amounts payable**  
**Payment arrangements**  
**Conditions attached to the amounts payable**

## **10. PAYMENTS FOR LOCUMS COVERING SICKNESS LEAVE**

**Entitlement to payments for covering sickness leave**  
**Ceilings on the amounts payable**  
**Payment arrangements**  
**Conditions attached to the amounts payable**

## **11. PAYMENTS FOR LOCUMS TO COVER FOR SUSPENDED DOCTORS**

**Eligible cases**  
**Ceilings on the amounts payable**  
**Payment arrangements**  
**Conditions attached to the amounts payable**

## **12. PAYMENTS IN RESPECT OF PROLONGED STUDY LEAVE**

**Types of study in respect of which Prolonged Study Leave may be taken**  
**The Educational Allowance Payment**  
**Locum cover in respect of doctors on prolonged study leave**  
**Payment arrangements**  
**Conditions attached to the amounts payable**

## **13. SENIORITY PAYMENTS**

**Eligible posts**  
**Service that is Reckonable Service**  
**Calculation of years of Reckonable Service**  
**Determination of the relevant dates**  
**Calculation of the full annual rate of Seniority Payments**  
**Superannuable Income Fractions**  
**Amounts payable**  
**Conditions attached to payment of Quarterly Seniority Payments**

## **14. GOLDEN HELLO SCHEME**

**Standard payments under the Golden Hello Scheme**  
**Payments for Practitioners in Areas attracting Additional Payments**  
**Job Sharers**  
**Changes in Circumstances**  
**Extra payments**

**Return of Payments  
Relocation Costs  
Recruitment Costs  
Rates of Payment**

## **15. ADULTS WITH INCAPACITY**

**Where an independent health professional seeks confirmation that a certificate of incapacity is in force  
Where a general practitioner is requested by an independent health professional to carry out an assessment**

## **16. NOT ALLOCATED**

## **17. DOCTORS' RETAINER SCHEME**

**Payments in respect of sessions undertaken by members of the Scheme  
Provisions in respect of leave arrangements  
Payment conditions**

## **18. DISPENSING**

**Transitional arrangements  
Claims  
Payments on account  
Examination of prescription forms  
Accounting  
Payments for the provision of flu vaccines  
Schedule 1 – Discount Scale  
Schedule 2 - Fee scale  
Schedule 3 – Address for claims  
Schedule 4 – List of Vaccines**

### ***PART 5 PREMISES AND IT EXPENSES***

## **19. PREMISES**

## **20. I.T. EXPENSES**

### ***PART 6 SUPPLEMENTARY PROVISIONS***

## **21. ADMINISTRATIVE PROVISIONS**

**Overpayments and withheld amounts  
Underpayments and late payments  
Payments on account  
Payments to or in respect of suspended doctors whose suspension ceases**



**Effect on periodic payments of termination of a GMS contract**  
**Time limitation for claiming payments**  
**Dispute resolution procedures**  
**Protocol in respect of locum cover payments**  
**Adjustment of Contractor Registered Populations**  
**Default contracts and payments to persons not able to enter into default contracts**

## **22. SUPERANNUATION CONTRIBUTIONS**

**Health Boards' responsibilities in respect of contractors' employer's and employee's superannuation contributions**  
**Monthly deductions in respect of superannuation contributions**  
**End-year adjustments**  
**Locums**

### *ANNEXES*

- A. Glossary*
- B. Scottish Allocation Formula*
- C. Temporary Patients Adjustment*
- D. Not Allocated*
- E. Quality and Outcomes Framework*
- F. Calculation of Additional Services Achievement Points*
- G. Adjusted Practice Disease Factor Calculations*
- H. List of Health Board areas for which additional payments are payable under the Golden Hello Scheme*
- I. Pneumococcal and Hib/MenC Booster vaccinations and Pneumococcal Catch-up Campaign*
- J. Vaccinations and Immunisations to be provided under Additional Services*

# 1. Introduction

1.1 Scottish Ministers, in exercise of the powers conferred upon them by section 17M and 105(6) of the National Health Service (Scotland) Act 1978<sup>1</sup>, and of all other powers enabling them in that behalf, after consulting in accordance with section 17M(4) of the 1978 Act both with the bodies appearing to them to be representative of persons to whose remuneration these directions relate and with such other persons as they think appropriate, gives the directions set out in this Statement of Financial Entitlements (“SFE”).

1.2 This SFE relates to the payments to be made by Health Boards to a contractor under a general medical services (“GMS”) contract. It replaces the Statement of Financial Entitlements, signed on 15 October 2010 and effective from 1 April 2010. Previous SFEs continue to have effect in relation to claims for payments that relate to the relevant financial years.

1.3 The directions set out in this SFE are subordinate legislation for the purposes of section 23 of the Interpretation Act 1978, and accordingly, in this SFE, unless the context otherwise requires–

- (a) words or expressions used here and the 1978 Act bear the meaning they bear in the 1978 Act;
- (b) references to legislation (i.e. Acts and subordinate legislation) are to that legislation as amended, extended or applied, from time to time;
- (c) words importing the masculine gender include the feminine gender, and *vice versa* (words importing the neuter gender also include the masculine and feminine gender); and
- (d) words in the singular include the plural, and *vice versa*.

1.4 This SFE is divided into Parts, Sections, paragraphs, sub-paragraphs and heads. A Glossary of some of the words and expressions used in this SFE is provided in Annex A. Words and expressions defined in that Annex are generally highlighted by initial capital letters.

1.5 The directions given in this SFE apply to Scotland only. They were authorised to be given, and by an instrument in writing, on behalf of Scottish Ministers, by Frank Strang, a member of the Senior Civil Service, on 25 October 2011 and came into force with effect from 1 April 2011.

1.6 This SFE may be revised at any time, in certain circumstances with retrospective effect.<sup>2</sup> For the most up-to-date information, contact the Scottish Government Health Directorates, Directorate for Health and Social Care Integration,

---

<sup>1</sup> Section 17M was inserted by section 4 of the Primary Medical Services (Scotland) Act 2004.

<sup>2</sup> See section 17M(3)(e) of the NHS (Scotland) Act 1978

Primary Medical Services Branch, Area 1.ER, St Andrews House, Regent Road,  
EDINBURGH, EH1 3DG.

signed by authority of the Scottish Ministers



Frank Strang  
Scottish Government Health Directorates: A member of the Senior Civil Service  
25 October 2011

## PART 1

# GLOBAL SUM AND MINIMUM PRACTICE INCOME GUARANTEE

## 2. Global Sum Payments

2.1. Global Sum Payments are a contribution towards the contractor's costs in delivering essential and additional services, including its staff costs. Although the Global Sum Payment is notionally an annual amount, it is to be revised quarterly and a proportion paid monthly.

### *Calculation of a contractor's first Initial Global Sum Monthly Payment*

2.2 At the start of each financial year – or, if a GMS contract starts after the start of the financial year, for the date on which the GMS contract takes effect – Health Boards must calculate for each contractor its first Initial Global Sum Monthly Payment (“Initial GSMP”) value for the financial year. This calculation is to be made by first establishing the contractor's Contractor Registered Population (CRP)–

- (a) at the start of the financial year; or
- (b) if the contract takes effect after the start of the financial year, on the date on which the contract takes effect.

2.3 The Scottish Allocation Formula, a summary of which is included in Annex B of this SFE, determines how the total Global Sum amount for Scotland is to be distributed to all practices in Scotland. Once the contractor's CRP has been established, this number is to be adjusted by the Scottish Allocation Formula. The resulting figure, which is the contractor's Contractor Weighted Population for the Quarter. It is on the basis of the Contractor Weighted Population for the Quarter, relative to the Scotland-wide Weighted Population for the Quarter, that the practice is allocated its share of the Scotland-wide global sum, not including the sums allocated for Temporary Patients Adjustments. From 1 April 2011 the global sum amount for Scotland is increased to £389.0 million reflecting the increase in aggregate contractor registered populations from 1 April 2010 to 1 April 2011

2.4 For comparative purposes only, this figure should correspond to the Contractors Weighted Population for the Quarter multiplied by approximately £70. This figure is calculated by taking the total global sum amount for Scotland (£389.0m), subtracting the total sum allocated for Temporary Patients Adjustments and then dividing by the Scotland-wide registered population for the Quarter.<sup>3</sup> The

---

<sup>3</sup> The figure of £389.0m takes effect with this SFE on 1 April 2011 and includes non-GMS practices. The equivalent figure prior to 1 April 2011 was £387.7m. The new figure reflects the change in Scotland's registered populations for the period 01 April 2010 to 31 March 2011.



resulting amount is then to be divided by twelve, and the resulting amount from that calculation is the contractor's first Initial GSMP for the financial year.

***Calculation of Adjusted Global Sum Monthly Payments***

2.5 If, where a first Initial GSMP for the financial year has been calculated, the relevant GMS contract stipulates that the contractor is not to provide one or more of the Additional or Out-of-Hours Services listed in column 1 of the Table in this paragraph, the Health Board is to calculate an Adjusted GSMP for that contractor as follows. If the contractor is not going to provide–

- (a) one of the Additional or Out-of-Hours Services listed in column 1 of the Table, the contractor's Adjusted GSMP will be its Initial GSMP reduced by the percentage listed opposite the service it is not going to provide in column 2 of the Table;
- (b) more than one of the Additional or Out-of-Hours Services listed in column 1 of the Table, an amount is to be deducted in respect of each service it is not going to provide. The value of the deduction for each service is to be calculated by reducing the contractor's Initial GSMP by the percentage listed opposite that service in column 2 of the Table, without any other deductions from the Initial GSMP first being taken into account. The total of all the deductions in respect of each service is then deducted from Initial GSMP to produce the Adjusted GSMP.

**TABLE**

<i>Column 1</i>	<i>Column 2</i>
<b>Additional or Out-of-Hours Services</b>	<b>Percentage of Initial GSMP</b>
Cervical Screening Services	1.1
Child Health Surveillance	0.7
Minor Surgery	0.6
Maternity Medical Services	2.1
Contraceptive Services	2.4
Childhood immunisations and pre-school boosters	1.0
Vaccinations and immunisations	2.0
Out-of-Hours Services	6.0

***First Payable Global Sum Monthly Payment***

2.6 Once the first value of a contractor's Initial GSMP, and where appropriate Adjusted GSMP have been calculated, the Health Board must determine the gross amount of the contractor's Payable GSMP. This, is its Initial GSMP or, if it has one, its Adjusted GSMP. The net amount of a contractor's Payable GSMP, i.e. the amount actually to be paid each month, is the gross amount of its Payable GSMP minus any monthly deductions in respect of superannuation determined in accordance with Section 22 (see paragraph 22.6).

2.7 The Health Board must pay the contractor its Payable GSMP, thus calculated, monthly (until it is next revised). The Payable GSMP is to fall due on the last day of each month. However, if the contract took effect on a day other than the first day of a month, the contractor's Payable GSMP in respect of the first part-month of its contract is to be adjusted by the fraction produced by dividing—

- (a) the number of days during the month in which the contractor was under an obligation under its GMS contract to provide the Essential Services by
- (b) the total number of days in that month.

***Revision of Payable Global Sum Monthly Payments***

2.8 The amount of the contractor's Payable GSMP is thereafter to be reviewed—

- (a) at the start of each quarter;
- (b) if there are to be new Additional or Out-of-Hours Services opt-outs (whether temporary or permanent);
- (c) if the contractor is to start or resume providing specific Additional or Out-of-Hours Services that it has not been providing; or
- (d) if the amount specified in paragraph 2.3 is changed.

2.9 Whenever the Payable GSMP needs to be revised, the Health Board will first need to calculate a new Initial GSMP for the contractor (unless this cannot have changed). This is to be calculated in the same way as the contractor's first Initial GSMP (as outlined in paragraphs 2.3 and 2.4 above), but using the most recently established CRP of the contractor (the number is to be established quarterly).

2.10 Any deductions for Additional or Out-of-Hours Services opt-outs are then to be calculated in the manner described in paragraph 2.5. If the contractor starts or resumes providing specific Additional Services under its GMS contract to patients to whom it is required to provide essential services, then any deduction that had been made in respect of those services will need to be reversed. The resulting amount (if there are to be any deductions in respect of Additional or Out-of-Hours Services) is the contractor's new (or possibly first) Adjusted GSMP.

2.11 Once any new values of the contractor's Initial GSMP and Adjusted GSMP have been calculated, the Health Board must determine the gross amount of the contractor's new Payable GSMP. This is its (new) Initial GSMP or, if it has one, its (new or possibly first) Adjusted GSMP. The net amount of a contractor's Payable GSMP, i.e. the amount actually to be paid each month, is the gross amount of its Payable GSMP minus any monthly deductions in respect of superannuation determined in accordance with Section 22 (see paragraph 22.6).

2.12 Payment of the new Payable GSMP must (until it is next revised) be made monthly, and it is to fall due on the last day of each month. However, if a change is made to the Additional or Out-of-Hours Services that a contractor is under an obligation to provide and that change takes effect on any day other than the first day of the month, the contractor's Payable GSMP for that month is to be adjusted accordingly. Its amount for that month is to be the total of–

- (a) the appropriate proportion of its previous Payable GSMP. This is to be calculated by multiplying its previous Payable GSMP by the fraction produced by dividing–
  - (i) the number of days in the month during which it was providing the level of services based upon which its previous Payable GSMP was calculated, by
  - (ii) the total number of days in the month; and
- (b) the appropriate proportion of its new Payable GSMP. This is to be calculated by multiplying its new Payable GSMP by the fraction produced by dividing–
  - (i) the number of days left in the month after the change to which the new Payable GSMP relates takes effect, by
  - (ii) the total number of days in the month.

2.13 Any overpayment of Payable GSMP in that month as a result of the Health Board paying the previous Payable GSMP before the new Payable GSMP has been calculated is to be deducted from the first payment in respect of a complete month of the new Payable GSMP. If there is an underpayment for the same reason, the shortfall is to be added to the first payment in respect of a complete month of the new Payable GSMP.

#### ***Conditions attached to Payable Global Sum Monthly Payments***

2.14 Payable GSMPs, or any part thereof, are only payable if the contractor satisfies the following conditions–

- (a) the contractor must make available to the Health Board any information which the Health Board does not have but needs, and the contractor either has or could reasonably be expected to obtain, in order to calculate the contractor's Payable GSMP;
- (b) the contractor must make any returns required of it (whether computerised or otherwise) to Practitioner Services Division (PSD) of NHS National Services Scotland, and do so promptly and fully;
- (c) the contractor must immediately notify the Health Board if for any reason it is not providing (albeit temporarily) any of the services it is under an obligation to provide under its GMS contract; and

- (d) all information supplied to the Health Board pursuant to or in accordance with this paragraph must be accurate.

2.15 If the contractor breaches any of these conditions, the Health Board may, in appropriate circumstances, withhold payment of any or any part of a Payable GSMP that is otherwise payable.

2.16 It is also a condition of every contractor's Payable GSMPs that it achieves, in relation to each financial year in which it receives Payable GSMPs, an Achievement Points Total of at least 150, whether or not it participated in the Quality and Outcomes Framework. If it breaches this condition, the Health Board must withhold from the contractor the amount produced by multiplying–

- (a) 150; by
- (b) the amount specified in paragraph 6.6 as the value of each Achievement Point in a calculation of an Achievement Payment for the financial year to which the Achievement Points Total relates; by
- (c) the contractor's Contractor Population Index that is, or would be, used for the calculation of any Achievement Payment due to the contractor in respect of that financial year (the contractor will, in any event, receive an Achievement Payment in respect of the points it does score for that financial year, pursuant to section 6).

2.17 However, if the contractor's GMS contract either takes effect during, or is terminated before the end of, that financial year, the amount to be withheld pursuant to paragraph 2.16 is to be adjusted by the fraction produced by dividing the number of days during which the financial year for which its GMS contract had effect by 365 (or 366 where the financial year includes 29<sup>th</sup> February).

### ***Contractor Population Index***

2.18 The Contractor Population Index (CPI) of a contractor, mentioned in paragraph 2.16, is the contractor's most recently established CRP divided by 5188.<sup>4</sup> Where reference is made in this SFE to a contractor's CPI, that reference, unless the context otherwise requires, is to the most up-to-date version of the contractor's CPI at the time that the payment which is being adjusted in accordance with a calculation using the contractor's CPI falls due.

---

<sup>4</sup> The figure of 5188 takes effect with this SFE from 01 April 2011. The equivalent figure prior to 01 April 2011 was 5170. The new figure reflects the notional change in the Scotland's registered population for the period 01 April 2010 to 31 March 2011.

### 3. Minimum Practice Income Guarantee

3.1 The Minimum Practice Income Guarantee (MPIG) is based on the historic revenue of a contractor's GPs from the list in Annex D of the 2004/5 SFE, essentially of Red Book fees and allowances, and is essentially designed to protect those income levels. A one year aggregate of these protected income amounts is the contractor's Initial Global Sum Equivalent (GSE), which is then adjusted to produce first its Adjusted GSE and then its Final GSE.

3.2 MPIG calculations are one-off calculations made in respect of contractors whose GMS contracts took effect, or which were treated as taking effect for payment purposes, on 1st April 2004. Nevertheless, an explanation of how MPIG calculations were originally undertaken has been retained in this SFE for reference purposes. The basis of an MPIG calculation was one year aggregate of the protected income amounts mentioned in paragraph 3.1, which produced the contractor's Initial Global Sum Equivalent (GSE), which was then adjusted to produce first its Adjusted GSE and then its Final GSE.

#### *Calculation of Global Sum Equivalent*

3.3 In respect of contracts which took effect, or which were treated as taking effect for payment purposes, on 1st April 2004, in order to calculate a contractor's GSE, a calculation was first made of its Initial and Adjusted GSE. This was done by the Health Board—

- (a) on the basis of information obtained by it from the contractor about payments to the contractor (or the GPs comprising the contractor) under the Red Book, and in particular in the year preceding 1st July 2003;
- (b) in accordance with the Scottish Government Health Directorate (SGHD) guidance reproduced in Annex D of the 2004/5 SFE; and
- (c) Details of GSE allocations for previous Inducement Practitioners are at Annex D part 2 of the 2004/5 SFE.

3.4 Whether or not any adjustments are in fact necessary to Initial GSE, the final total produced as a result of the calculation in accordance with Annex D of the 2004/5 SFE was known as the contractor's Adjusted GSE. That amount was then subject to three further adjustments—

- (a) the amount was increased by 2.85% to bring prices in respect of the year ending 30th June 2003 up to 31st March 2004 levels (i.e. rebasing for the financial year 2003 to 2004); then
- (b) the sub-paragraph (a) amount was increased by 1.47% to take account of projected price increases in respect of the financial year 2004 to 2005 (i.e. rebasing for the financial year 2004 to 2005).

- (c) the sub-paragraph (b) amount was added to the contractor's GSE Superannuation Adjustment. This was an adjustment to take account of the additional employer's superannuation contributions in respect of GPs and practice staff as a result of the Treasury transfer. The contractor's GSE Superannuation Adjustment was calculated by adjusting its total amount of superannuation contributions up to a level equating to 14% contributions.

The resulting amount was the contractor's Final GSE.

### ***Calculation of Correction Factor Monthly Payments***

3.5 The contractor's Final GSE was then compared to the paragraph 2.3 total in respect of the contractor. In the financial year 2004 to 2005, a contractor's paragraph 2.3 total was the annual amount of its first Initial Global Sum Payment, excluding its Temporary Patients Adjustment and minus two adjustments in that financial year which have since been discontinued: a Superannuation Premium and an Appraisal Premium. From that paragraph 2.3 total was subtracted any Historic Opt-Outs Adjustment to which the contractor was entitled.

3.6 A contractor was entitled to the Historic Opt-Outs Adjustment if–

- (a) between 1<sup>st</sup> July 2002 and 1<sup>st</sup> April 2004, the GPs comprising the contractor have not been providing, within GMS services, services which as far as possible were equivalent to one or more of the Additional or Out-of-Hours Services listed in the Table in paragraph 2.5; and
- (b) the contractor would not be providing those services in the financial year 2004 to 2005.

3.7 The amount of the contractor's Historic Opt-Outs Adjustment was calculated as follows. If the contractor is claiming an Historic Opt-Outs Adjustment in respect of–

- (a) one of the Additional or Out-of-Hours Services listed in column 1 of the Table in paragraph 2.5, the value of the contractor's Historic Opt-Outs Adjustment was the amount by which its paragraph 2.3 total would be reduced if it was reduced by the percentage listed opposite that service in column 2 of the Table;
- (b) more than one of the Additional or Out-of-Hours Services listed in column 1 of the Table in paragraph 2.5, the value of the contractor's Historic Opt-Outs Adjustment was to include an amount in respect of each service. The value of the amount for each service was the amount by which the contractor's paragraph 2.3 total would be reduced if it was reduced by the percentage listed opposite that service in column 2 of the Table, without any other deductions from the paragraph 2.3 total first being taken into account. The total of all the amounts in respect of

each service was then aggregated to produce the final amount of the contractor's Historic Opt-Outs Adjustment.

3.8 Accordingly, a contractor's paragraph 2.3 total, minus any Historic Opt-Outs Adjustment to which it was entitled, was its Global Sum Comparator.

3.9 If the contractor's Final GSE was less than its Global Sum Comparator, a Correction Factor was not payable in respect of that contractor. However, if its Final GSE was greater than its Global Sum Comparator, Correction Factor Monthly Payments ("CFMPs") had to be paid by the Health Board to the contractor under its GMS contract. The amount of the CFMPs payable was the difference between the contractor's Final GSE and its Global Sum Comparator, divided by twelve.

***Review and revision of Correction Factor Monthly Payments in respect of financial year 2011/12 and financial years thereafter.***

3.10 At the start of each financial year, Health Boards must determine which of their contractors are entitled to CFMPs. Generally, these will be:

a) the contractors to which CFMPs were payable at the end of the previous financial year and which are still in existence at the start of the new financial year; and

b) any contractors affected by a partnership merger or split whose contract takes effect at the start of the financial year and who, by virtue of the paragraphs 3.16 to 3.19 below, is entitled to receive CFMPs calculated in accordance with those paragraphs.

3.11 The baseline monthly figure amount for the calculation of a contractor's CFMP for a new financial year is established as follows:

a) in the case of a contractor affected by a partnership merger or split that takes effect at the start of the financial year, if, by virtue of paragraphs 3.16 to 3.19 below, the contractor becomes entitled to CFMPs, or the amount of its CFMPs is to change, a calculation must first be made of the amount to which it would have been entitled as a CFMP in the previous financial year, had the merger or split taken effect then, and that amount is to be the baseline monthly figure amount for the calculation of its CFMPs for the new financial year;

b) in all other cases, the baseline monthly amount for the calculation of the contractor's CFMPs for the new financial year will be the monthly figure for any CFMP that was payable at the end of the previous financial year.

3.12 Once the baseline monthly figure amount of a contractor's CFMPs has been established, that amount- is to be uprated

(a) for the financial year 2011 to 2012 by 0%; and

(b) for the financial year 2012 to 2013 and subsequent financial years, by-

- (i) the percentage by which the amount specified in paragraph 2.3 is uprated at or for the start of the new financial year (“the Uprating Percentage”), if it is to be uprated, or
- (ii) if the first amount specified in paragraph 2.3 is not to be uprated at or for the start of the new financial year, by 0%”,

3.13 So, if the amount specified in paragraph 2.3 is uprated at or for the start of the new financial year, the amount of the contractor’s CFMPs for the new financial year is to be its baseline amount, as increased by the Uprating Percentage; otherwise, the amount of a contractor’s CFMPs for the new financial year is to be its baseline amount<sup>5</sup> CFMPs are to fall due on the last day of each month

3.14 Thereafter, throughout the new financial year, unless the contractor is subject to a partnership merger or split, the amount of the contractor’s CFMPs is to remain unchanged, even if the amount of the contractor’s Payable GSMP changes.

***Practice mergers or splits***

3.15 Except as provided for in paragraphs 3.16 to 3.20, a contractor with a GMS contract which takes effect, or is treated as taking effect for payment purposes, after 1st April 2004 will not be entitled to CFMPs.

3.16 If-

- (a) a new contractor comes into existence as the result of a merger between one or more other contractors; and
- (b) that merger led to the termination of GMS contracts and the agreement of a new GMS contract,

the new contractor is to be entitled to a CFMP that is the total of any CFMPs payable under the terminated GMS contracts.

3.17 If-

- (a) a new contractor comes into existence as the result of a partnership split of a previous contractor (including a split in order to reconstitute as a company limited by shares;
- (b) at least some of the members of the new contractor were members of the previous contractor; and
- (c) the split led to the termination of the previous contractor’s GMS contract,

---

<sup>5</sup> In future years, if there are increases to global sum payments to take into account additional investment, the method of calculating the Uprating Percentage is likely to change.



the new contractor will be entitled to a proportion of any CFMP payable under the terminated contract. The proportions are to be worked out on a *pro rata* basis, based upon the number of patients registered with the previous contractor (i.e. immediately before its contract is terminated) who will be registered with the new contractor when its new contract takes effect.

3.18 However, where a contractor that is a company limited by shares becomes entitled to CFMPs as a consequence of a partnership split in order to reconstitute as a company limited by shares, that entitlement is conferred exclusively on that company and is extinguished if that company is dissolved. Following such a dissolution, discretionary payments under section 17Q of the 1978 Act, equivalent to correction factor payments, could be made by the Health Board to a new contractor to whom the extinguished company's patients are transferred. Such payments may be appropriate, for example, where a group of providers in a partnership become a company limited by shares and then again a partnership, but all the while they continue to provide essentially the same services to essentially the same number of patients.

3.19 If-

- (a) a new GMS contract is agreed by a contractor which has split from a previously established contractor; but
- (b) the split did not lead to the termination of the previously established contractor's GMS contract,

the new contractor will not be entitled to any of the previously established contractor's CFMP unless, as a result of the split, an agreed number, or a number ascertainable by the Health Board(s) for the contractors, of patients have transferred to the new contractor at or before the end of the first full quarter after the new GMS contract takes effect.

3.20 If such a transfer has taken place, the previously established contractor and the new contractor are each to be entitled to a proportion of the CFMP that has been payable under the previously established contractor's GMS contract. The proportions are to be worked out on a *pro rata* basis. The new contractor's fraction of the CFMP will be—

- (a) the number of patients transferred to it from the previously established contractor; divided by
- (b) the number of patients registered with the previously established contractor immediately before the split that gave rise to the transfer.

and the old contractor's CFMP is to be reduced accordingly.

***Conditions attached to payment of Correction Factor Monthly Payments***

3.21 CFMPs, or any part thereof, are only payable if the contractor satisfies the following conditions–

- (a) the contractor must make available any information which the Health Board does not have but needs, and the contractor either has or could reasonably be expected to obtain, in order to calculate the contractor’s CFMP; and
- (b) all information supplied pursuant to or in accordance with this paragraph must be accurate.

3.22 If the contractor breaches any of these conditions, the Health Board may, in appropriate circumstances, withhold payment of any or any part of a CFMP that is otherwise payable.

## PART 2

### QUALITY AND OUTCOMES FRAMEWORK

#### 4. Quality and Outcomes Framework: General

4.1 The Quality and Outcomes Framework (QOF) is set out in Annex E to this SFE. Participation in the QOF is voluntary.

##### *Types of payments in relation to the QOF*

4.2 Essentially, there are two types of payments that are made in relation to the QOF: Aspiration Payments and Achievement Payments. Aspiration Payments are, in effect, a part payment in advance in respect of achievement under the QOF, and may be calculated using one of two different methods–

- (a) a calculation based on 70% of the contractor's previous year's Unadjusted Achievement Payment; or
- (b) a calculation based on the total number of points that a contractor has agreed with a Health Board that it is aspiring towards under the QOF during the financial year in respect of which the Aspiration Payment is made. This total is its Aspiration Points Total. The points available are set out in the QOF indicators in the QOF, which have numbers of points attached to particular performance indicators (negative points totals in relation to indicators are always to be disregarded).

4.3 If a contractor is to have an Aspiration Points Total, this is to be agreed between it and the Health Board–

- (a) at the start of the financial year; or
- (b) if its GMS contract takes effect after the start of the financial year, for its GMS contract takes effect.

4.4 Achievement Payments are payments based on the points total that the contractor achieves under the QOF – as calculated, generally speaking (see paragraph 6.2), on the last day of the financial year or the date on which its contract terminates (this points total is its Achievement Points Total). The payments are to be made in respect of all Achievement Points actually achieved, whether or not the contractor was seeking to achieve those points, but the final amount also takes into account the deduction of the Aspiration Payments that the contractor has received in respect of the same financial year.

### ***The four principal domains of the QOF***

4.5 The QOF is divided into four principal domains, which are: the clinical domain; the organisational domain; the patient experience domain; and the additional services domain.

### ***Calculation of points in the clinical domain***

4.6 The clinical domain contains twenty clinical areas, for each of which there are a number of indicators set out in tables in Section 2 of the QOF. These indicators contain standards against which the performance of the contractor will be assessed.

4.7 Some of the indicators simply require particular tasks to be accomplished (i.e. the production of disease registers), and the standards contained in the indicators do not have, opposite them in the tables of indicators, percentage figures for Achievement Thresholds. The points available in relation to these indicators are only obtainable (and then in full) if the task is accomplished. Guidance on what is required to accomplish these tasks is given in Section 2 of the QOF.

4.8 Other indicators have designated Achievement Thresholds. The contractor's performance against the standards set out in these indicators is assessed by a percentage – generally of the patients suffering from a particular disease in respect of whom a specific task is to be performed or a specific outcome recorded. Two percentages are set in relation to each indicator–

- (a) a minimum percentage of patients, which represents the start of the scale (i.e. with a value of zero points); and
- (b) a maximum percentage of patients, which is the lowest percentage of eligible patients in respect of whom the task must be performed or outcome recorded in order to qualify for all the points available in respect of that indicator.

4.9 If a contractor has achieved a percentage score in relation to a particular indicator that is the minimum set for that indicator, or is below that minimum, it achieves no points in relation to that indicator. If a contractor has achieved a percentage score in relation to a particular indicator that is between the minimum and the maximum set for that indicator, it achieves a proportion of the points available in relation to that indicator. The proportion is calculated as follows.

4.10 First, a calculation will have to be made of the percentage the contractor actually scores (D). This is calculated from the following fraction: divide–

- (a) the number of patients registered with the contractor in respect of whom the task has been performed or outcome achieved (A); by
- (b) the number produced by subtracting from the total number of patients registered with the contractor with the relevant medical condition (B)

the number of patients to be excluded from the calculation on the basis of the provisions in the QOF on exception reporting (C).

The provisions on exception reporting are set out in Section 2.3 of the QOF. This fraction is then multiplied by 100 for the percentage score. The calculation can be expressed as:  $\frac{A}{(B - C)} \times 100 = D$ .

4.11 Once the percentage the contractor actually scores has been calculated (D), subtract from this the minimum percentage score set for that indicator (E), then divide the result by the difference between the maximum (F) and minimum (E) percentage scores set for that indicator, and multiply the result of that calculation by the total number of points available in relation to that indicator (G). This can be expressed as:

$$\frac{(D - E)}{(F - E)} \times G.$$

4.12 The result is the number of points to which the contractor is entitled in relation to that indicator.

### ***Calculation of points in the organisational domain***

4.13 This domain is itself split into six further sub-domains: records and information; information for patients; education and training; practice management; medicines management and quality and productivity. Section 3 of the QOF contains a number of indicators for each of these sub-domains, which in turn contain standards against which the performance of the contractor will be assessed.

4.14.1 With the exception of-

(a) the indicator “records 23” in the records and information sub-domain (the percentage of patients aged 16 and over whose notes record smoking status in the past 27 months), and

(b) the prescribing indicators in the quality and productivity sub-domain,

the standards set relate to the task to be performed or an outcome to be achieved. The points available in relation to the indicators (other than those mentioned in subparagraph (a) and (b)) are only obtainable in full if the task is in fact accomplished or the outcome achieved.

4.14.2 Guidance on what is required to accomplish the task or achieve the outcome is given in Section 3 of the QOF. In particular, the quality and productivity achievement will be measured in accordance with that Section, and in the case of the prescribing indicators, also in accordance with paragraph 4.14B.

4.14A “Records 23” has designated achievement thresholds and the standard of the performance of the contractor is to be assessed in accordance with Section 4.8 to 4.12.

4.14B The quality and productivity prescribing indicators-

- (a) QP1 and QP2 have designated tasks to be performed and outcomes to be achieved and these are set out in Section 3,
- (b) will only result in the availability of points in relation to indicator QP2 where indicator QP1 has been fully accomplished,
- (c) will only result in an entitlement to a payment in respect of indicators QP3, QP4 or QP5 if QP1 and QP2 have been achieved, and
- (d) in respect of indicators QP3, QP4 and QP5 will be measured in accordance with the methodology set out in Section 3 and Health Boards will calculate the achievements for those indicators using PRISMS data.

***Calculation of points in the patient experience domain***

4.15 The patient experience domain contains one indicator which is set out in Section 4 of the QOF and relates to the length of patient consultations. The points available for this indicator will only be obtainable (and then in full) if the relevant outcomes recorded are achieved.

4.16 Guidance on what is required to gain the points set out in this domain is given in Section 4 of the QOF.

***Calculation of points in the additional services domain***

4.17 The additional services domain relates to the following Additional Services: cervical screening services; child health surveillance; maternity services; and contraceptive services. For each of these services, there are a number of indicators, set out in tables in Section 5 of the QOF, which contain standards against which the performance of the contractor will be assessed.

4.18 The child health surveillance and maternity medical services indicators require particular services to be offered – and the points available in relation to these indicators will only be obtainable (and then in full) if the service is offered to the relevant target population.

4.19 The first contraceptive indicator (SH1) and all but one of the cervical screening services indicators require particular tasks to be performed in relation to a target population, and the points available in relation to these indicators will only be obtainable (and then in full) if the task is accomplished.

4.20 The second and third contraceptive indicators (SH2 and SH3) and one of the cervical screening services indicators (CS1) have designated achievement thresholds, and the method for calculating points in relation to these indicators is the same as the method for calculating points in relation to this type of indicator in the clinical domain.

4.21 Guidance on what is required to gain the points set out in this domain is given in Section 5 of the QOF.

## **5. Aspiration Payments**

### ***Calculation of Monthly Aspiration Payments: general***

5.1 At the start of each financial year – or if a GMS contract starts after the start of the financial year, for the date on which the GMS contract takes effect – subject to paragraph 5.2(b), Health Boards must calculate for each contractor that has agreed to participate in the QOF the amount of its Monthly Aspiration Payments for that, or for the rest of that, financial year.

5.2 As indicated in paragraph 4.2 above, there are two methods by which a contractor's Monthly Aspiration Payments may be calculated. Each contractor may choose the method by which its Monthly Aspiration Payments are calculated, if it is possible to calculate Monthly Aspiration Payments in respect of the contractor by both methods. However–

- (a) if it is only possible to calculate a Monthly Aspiration Payments in respect of the contractor by basing the calculation on an Aspiration Points Total, that is the method which is to be used; and
- (b) if the contractor's GMS contract is to take effect on or after 2nd February but before 1st April, no Aspiration Points Total is to be agreed for the financial year into which that 2nd February falls, so the contractor will not be able to claim Monthly Aspiration Payments in that financial year. However, the contractor will nevertheless be entitled to Achievement Payments under the QOF if it participates in the QOF.

### ***Calculation of Monthly Aspiration Payments: the 70% method***

5.3 If–

- (a) the contractor's GMS contract took effect before the start of the financial year in respect of which the claim for Monthly Aspiration Payments is made; and
- (b) in respect of the previous financial year the contractor was entitled to an Achievement Payment, under this SFE,

that contractor's Monthly Aspiration Payments may be calculated using the 70% method.

5.4 To calculate a contractor's Monthly Aspiration Payments by the 70% method, the contractor's Unadjusted Achievement Payment for the previous year needs to be established that is, the total established under paragraph 5.39 of the 2004/5 SFE or paragraph 6.7 of this SFE. Generally, this will not be possible in the first quarter of the financial year, and so a Provisional Achievement Payment will need to be established by the Health Board. The amount of this payment is to be based on the contractor's return submitted in accordance with paragraph 5.35 of the 2004/5 SFE or paragraph 6.3 of this SFE. This amount will not include any element attributable to



any entitlement in respect of the patient experience of access indicators in the patient experience domain.

5.5 In practice, therefore, the amount of the contractor's Provisional Achievement Payment will be a provisional value for the contractor's Unadjusted Achievement Payment.

5.6 Once an annual amount for the contractor's Provisional Achievement Payment has been determined, this is to be multiplied by the QOF Uprating Index for the financial year. The QOF Uprating Index is to be determined by dividing–

- (a) the amount specified in paragraph 6.6 as the value of each Achievement Point for the financial year in respect of which the claim for Monthly Aspiration Payments is being made; by
- (b) the amount that was specified in paragraph 6.6 in respect of the previous financial year,

and rounding the resulting figure to fifteen decimal places.

5.7 The total produced by paragraph 5.6 is then to be multiplied by 70%. This figure is then further multiplied by the figure which is the product of the maximum number of points available under the QOF for the financial year in respect of which the calculation is being made divided by the maximum number of points available under the QOF in the previous financial year. (By way of example, the figures used for this element of the calculation in the financial year 2006/07 were 1000 and 1050 respectively, 1000 points being the maximum number of points available under the QOF for the financial year 2006/07 and 1050 being the maximum number of points available under the QOF for the financial year 2005/06.) The resulting figure is the annual amount of the contractor's Aspiration Payment. This is then to be divided by twelve for what, subject to paragraphs 5.9, 5.10 and 6.10, is to be the contractor's Monthly Aspiration Payment, as calculated by the 70% method.

5.8 Once the correct amount of the contractor's Achievement Payment in respect of the previous financial year has been established, the amount of the Monthly Aspiration Payments of a contractor whose payments were calculated using a Provisional Achievement Payment is to be revised. First, the difference between its Unadjusted Achievement Payment and its Provisional Achievement Payment is to be established. If this figure is zero, there is to be no change to the contractor's Monthly Aspiration Payments for the rest of the financial year.

5.9 If the Provisional Achievement Payment is higher than the Unadjusted Achievement Payment calculated for the contractor, the difference between the two is to be divided by the number of complete months left in the financial year after the actual Achievement Payment is paid. The amount produced by that calculation is to be deducted from each of the contractor's Monthly Aspiration Payments in respect of those complete months, thus producing the revised amount of that contractor's Monthly Aspiration Payments for the rest of the financial year.

5.10 If the Provisional Achievement Payment is lower than the Unadjusted Achievement Payment calculated for the contractor, the difference between the two is to be divided by the number of complete months left in the financial year after the actual Achievement Payment is paid. The amount produced by that calculation is to be added to each of the contractor's Monthly Aspiration Payments in respect of those complete months, thus producing the revised amount of that contractor's Monthly Aspiration Payments for the rest of the financial year.

***Calculation of Monthly Aspiration Payments: the Aspiration Points Total method***

5.11 Any contractor who is participating in the QOF may instead have their Monthly Aspiration Payments calculated by the Aspiration Points Total method, provided that its GMS contract takes effect before 2nd February in the financial year in respect of which the claim for Monthly Aspiration Payments is made.

5.12 If the contractor is to have its Monthly Aspiration Payments calculated by this method, at the start of each financial year – or if a GMS contract starts after the start of the financial year, for the date on which the GMS contract takes effect – an Aspiration Points Total is to be agreed between the contractor and the Health Board. As indicated in paragraph 4.2(b) above, an Aspiration Points Total is the total number of points that the contractor has agreed with a Health Board that it is aspiring towards under the QOF during the financial year in respect of which the Aspiration Payment is made.

5.13 If the Health Board and the contractor have agreed an Aspiration Points Total for the contractor, that total is to be divided by three. The resulting figure is to be multiplied by £130.38, and then by the contractor's CPI, which produces the annual amount of the contractor's Aspiration Payment. This is then to be divided by twelve for what, subject to paragraph 6.10, is to be the contractor's Monthly Aspiration Payment, as calculated by the Aspiration Points Total method.

***Payment arrangements for Monthly Aspiration Payments***

5.14 If, as regards any financial year, a contractor could have its Monthly Aspiration Payments calculated by either the 70% method or the Aspiration Points Total method, it must choose the method by which it wishes its Monthly Aspiration Payments to be calculated, and once it has made that choice, it cannot change that choice as regards that financial year.

5.15 The Health Board must thereafter pay the contractor under its GMS contract its Monthly Aspiration Payment monthly. The Monthly Aspiration Payment is to fall due on the last day of each month. However, if the contractor's contract took effect on a day other than the first day of a month, its Monthly Aspiration Payment in respect of that first part month (which will have been calculated by the Aspiration Points Total method) is to be adjusted by the fraction produced by dividing–

- (a) the number of days during the month in which the contractor was participating in the QOF; by
- (b) the total number of days in that month.

5.16 The amount of a contractor's Monthly Aspiration Payments is thereafter to remain unchanged throughout the financial year, even when its CPI changes or if the contractor ceases to provide an Additional Service and as a consequence is less likely to achieve the Aspiration Points Total that has been agreed.

***Conditions attached to Monthly Aspiration Payments***

5.17 Monthly Aspiration Payments, or any part thereof, are only payable if the contractor satisfies the following conditions–

- (a) as regards Monthly Aspiration Payments which are, or are to be, calculated by the Aspiration Points Total method–
  - (i) the contractor's Aspiration Points Total on which the Payments are based must be realistic, agreed with the Health Board and broken down for the Health Board by the contractor into a standard format, provided nationally, and
  - (ii) the contractor must make any returns required of it (whether computerised or otherwise) to PSD of NHS National Services Scotland, and do so promptly and fully;
- (b) the contractor must make available to the Health Board any information which the Health Board does not have but needs, and the contractor either has or could reasonably be expected to obtain, in order to calculate the contractor's Monthly Aspiration Payments;
- (c) contractors utilising accredited computer systems must make available to the Health Board, aggregated monthly information relating to their achievement of the standards contained in the indicators in the QOF, and in the standard form provided for by such systems,
- (d) contractors not utilising accredited computer systems must make available to the Health Board similar monthly returns, in such form as the Health Board reasonably requests (for example, Health Boards may reasonably request that contractors fill in manually a printout of the standard spreadsheet which is produced by accredited systems in respect of monthly achievement of the standards contained in the indicators in the QOF); and
- (e) all information supplied pursuant to or in accordance with this paragraph must be accurate.

5.18 If the contractor breaches any of these conditions, the Health Board may, in appropriate circumstances, withhold payment of any or any part of a Monthly Aspiration Payment that is otherwise payable.

## **6. Achievement Payments**

### ***Basis of Achievement Payments***

6.1 Achievement Payments are to be based on the Achievement Points to which a contractor is entitled at the end of the financial year, as calculated in accordance with this Section and Section 4.

6.2 The date in respect of which the assessment of achievement points is to be made is the last day of the financial year, subject to the following exceptions–

- (a) if a contractor is under an obligation, under its GMS contract, to provide an additional service for part of the financial year but ceases providing that service before the end of the financial year–
  - (i) permanently, or
  - (ii) temporarily, but does not then resume providing the service before the end of the financial year,

the assessment of the Achievement Points to which it is entitled in respect of that service is to be made in respect of the last date in the financial year on which it was under an obligation, under its GMS contract, to provide that service; and

- (b) if a GMS contract terminates before the end of the financial year, the assessment of the Achievement Points to which it is entitled is to be made in respect of the last date in the financial year on which it was under an obligation, under its GMS contract, to provide essential services.

### ***Returns in respect of Achievement Payments***

6.3 In order to make a claim for an Achievement Payment (except in relation to achievement of points relating to QP3, QP4 and QP5 of the prescribing indicators in the quality and productivity sub-domain of the Organisational Domain), a contractor must make a return in respect of the information required of it by the Health Board in order for the Health Board to calculate its Achievement Payment. Where a GMS contract terminates before the end of the financial year, a contractor may make a return at that stage in respect of the information necessary to calculate the Achievement Payment to which it is entitled in respect of that financial year.

6.4 On the basis of that return but subject to any revision of the Achievement Points totals that the Health Board may reasonably see fit to make–

- (a) to correct the accuracy of any points total; or
- (b) having regard to any guidance issued by SGHD,

the Health Board is to calculate the contractor's Achievement Payment as follows.

## *Calculation of Achievement Payments*

6.5 The parts of the Achievement Payment that relate to the clinical domain (other than the area relating to palliative care) and the additional services domain are calculated in a different way from the parts relating to the other domains. As regards–

- (a) the clinical domain (other than the area relating to palliative care), first a calculation needs to be made of an Adjusted Practice Disease factor for each disease area. (In the case of a GMS contract that only has effect for part of a financial year, there are specific provisions, set out in more detail in Annex G, as to the Adjusted Practice Disease Factor that is to be taken into account in calculating the contractor's Achievement Payment.) This is then multiplied by £130.38 and by the contractor's Achievement Points total in respect of the disease area to produce a cash amount for that disease area. Then the cash totals in respect of all the individual disease areas in the domain are to be added together to give the cash total in respect of the domain. A fuller explanation of the calculation of Adjusted Practice Disease Factors, and of the provisions that apply in the case of a GMS contract that only has effect for part of a financial year, is given in Annex G; and
- (b) the additional services domain, the Achievement Points Total in respect of each additional service is to be assessed in accordance with the guidance in Annex F, and a calculation is thereafter to be made of the cash total in respect of the domain in the manner set out in that guidance.

The part of the Achievement Payment that relates to the palliative care area of the clinical domain will be calculated in accordance with paragraph 6.6.

6.6 As regards all the other Achievement Points gained by the contractor, the total number of them is to be multiplied by £130.38.<sup>6</sup>

6.7 The cash totals produced under paragraphs 6.5 and 6.6 are then added together and multiplied by the contractor's CPI, calculated in accordance with the provisions of paragraph 2.18<sup>7</sup> –

- (a) at the start of the final quarter of the financial year to which the Achievement Payment relates;
- (b) if its GMS contract takes effect after the start of the final quarter of the financial year to which the Achievement Payment relates, on the date its GMS contract takes effect; or
- (c) if its GMS contract has been terminated, its CPI at the start of the quarter during which its GMS contract was terminated.

---

<sup>6</sup> The amount specified in paragraph 6.6 in respect of the financial year 2010 to 2011 was £127.28

6.8 If the contractor's GMS contract had effect –

- (a) throughout the financial year, the resulting amount is the interim total for the contractor's Achievement Payment for the financial year; or
- (b) for only part of the financial year, the resulting amount is to be adjusted by the fraction produced by dividing the number of days during the financial year for which the contractor's GMS contract had effect by 365 (or 366 where the financial year includes 29<sup>th</sup> February), and the result of that calculation is the interim total for the contractor's Achievement Payment for the financial year.

6.9 From these interim totals, the Health Board needs to subtract the total value of all the Monthly Aspiration Payments made to the contractor under its GMS contract in the financial year to which the Achievement Payment relates. The resulting amount (unless it is a negative amount or zero, in which case no Achievement Payment is payable) is the contractor's Achievement Payment for that financial year .

***Recovery where Aspiration Payments have been too high***

6.10 If the resulting amount from the calculation under paragraph 6.9 is a negative amount, that negative amount, expressed as a positive amount (“the paragraph 6.9 amount”), is to be recovered by the Health Board from the contractor in one of two ways–

- (a) to the extent that it is possible to do so, the paragraph 6.9 amount is to be recovered by deducting one twelfth of that amount from each of the contractor's Monthly Aspiration Payments for the financial year after the financial year to which the paragraph 6.9 amount relates. In these circumstances –
  - (i) the gross amount of its Monthly Aspiration Payments for accounting and superannuation purposes in the financial year after the financial year to which the paragraph 6.9 amount relates is to be the amount to which the contractor is otherwise entitled under paragraphs 5.7 to 5.10 or paragraph 5.13, and
  - (ii) the paragraph 6.9 amount is to be treated for accounting and superannuation purposes as an overpayment in respect of the contractor's Monthly Aspiration Payments for the financial year to which the paragraph 6.9 amount relates; or
- (b) if it is not possible to recover all or part of the paragraph 6.9 amount by the method described in sub-paragraph (a) (for example, because of the termination of the GMS contract after a partnership split), the amount that cannot be so recovered is to be treated as an overpayment in respect of the contractor's Monthly Aspiration Payments for the year to which the paragraph 6.9 amount relates, and is to be recovered accordingly (i.e. in accordance with paragraph 21.1).

6.11 Where the resulting amount from the calculation under paragraph 5.40 of the 2004/5 SFE is a negative amount, that negative amount, expressed as a positive amount (“the paragraph 5.40 amount”), is to be treated as an overpayment in respect of the contractor’s Payable GSMPs for the financial year 2005 to 2006, and is to be recovered accordingly (i.e. in accordance with paragraph 21.1).

***Accounting arrangements and due date for Achievement Payments***

6.12 The contractor’s Achievement Payment, as calculated in accordance with paragraph 6.9, is to be treated for accounting and superannuation purposes as gross income of the contractor in the financial year into which the date in respect of which the assessment of Achievement Points on which the Achievement Payment is based (“the relevant date”) falls, and the Achievement Payment is to fall due–

(a) where the GMS contract terminates before the end of the financial year into which the relevant date falls, at the end of the quarter after the quarter during which the GMS contract was terminated, and

(b) in all other cases, at the end of the first quarter of the financial year after the financial year into which the relevant date falls.

***Conditions attached to Achievement Payments***

6.13 Achievement Payments, or any part thereof, are only payable if the contractor satisfies the following conditions–

- (a) the contractor must make the return required of it under paragraph 6.3;
- (b) the contractor must ensure that all the information that it makes available to the Health Board in respect of the calculation of its Achievement Payment is based on accurate and reliable information, and that any calculations it makes are carried out correctly;
- (c) the contractor must ensure that it is able to provide any information that the Health Board may reasonably request of it to demonstrate that it is entitled to each Achievement Point to which it says it is entitled, and the contractor must make that information available to the Health Board on request;
- (d) the contractor must make any returns required of it (whether computerised or otherwise) to PSD of NHS National Services Scotland, and do so promptly and fully;
- (e) the contractor must co-operate fully with any reasonable inspection or review (including the Health Board’s QOF annual review) that the Health Board or another relevant statutory authority wishes to undertake in respect of the Achievement Points to which it says it is entitled; and

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

6.14 If the contractor breaches any of these conditions, the Health Board may, in appropriate circumstances, withhold payment of all or part of an Achievement Payment that is otherwise payable.



## PART 3

### DIRECTED ENHANCED SERVICES

#### 7. NOT ALLOCATED

#### 8. Childhood Immunisations Scheme

8.1 Childhood Immunisation and Pre-school Booster Services are classified as Additional Services. If contractors are providing these services to patients registered with them, Health Boards are to seek to agree a Childhood Immunisations Scheme plan with them, as part of their GMS contract. This plan will be the mechanism under which the payments set out in this Section will be payable.

##### *Childhood Immunisations Scheme plans*

8.2 Childhood Immunisations Scheme plans are to cover the matters set out in direction 4(2)(a) to (g) of the DES Directions.

##### *Target payments in respect of two-year-olds*

8.3 Health Boards must pay to a contractor under its GMS contract a Quarterly Two-Year-Olds Immunisation Payment (“Quarterly TYOIP”) if it qualifies for that payment. A contractor qualifies for that payment if, on the first day of a quarter–

- (a) the contractor has, as part of its GMS contract, a Childhood Immunisations Scheme plan which has been agreed with its Health Board; and
- (b) subject to paragraph 8.3A, as regards the cohort of children, established on that day, who are registered with the contractor and who are aged two (i.e. who have passed their second birthday but not yet their third), by the end of that quarter at least 70%, for the lower payment, or at least 90%, for the higher payment, have completed the recommended immunisation courses (ie those that have been recommended nationally and by the World Health Organisation) for protection against–
  - (i) diphtheria, tetanus, poliomyelitis, pertussis and Haemophilus influenzae type B (HiB);
  - (ii) measles/mumps/rubella, and
  - (iii) Meningitis C.

8.3A In establishing whether the required percentage of the cohort of children referred to in paragraph 8.3 have completed the recommended immunisations courses referred to in that paragraph, the Health Board is not required to determine whether any of that cohort have received the Hib/MenC Booster, recommended in the provisions set out at Annex I to this SFE, for administration around the age of 12 months. The administration of that Hib/MenC booster vaccination is not a requirement for payment under this Section.

### *Calculation of Quarterly Two-Year-Olds Immunisation Payment*

8.4 Health Boards will first need to determine the number of completed immunisation courses that are required over the three disease groups in paragraph 8.3(b) in order to meet either the 70% or 90% target. To do this the contractor will need to provide the Health Board with the number of two-year-olds (**A**) whom it is under a contractual obligation to include in its Childhood Immunisations Scheme Register on the first day of the quarter in respect of which the contractor is seeking payment (this is the cohort of children in respect of whom the calculation is to be made), and then the Health Board must make the following calculations–

- (a)  $(0.7 \times \mathbf{A} \times 4) = \mathbf{B}^1$  (the number of completed immunisation courses needed to meet the 70% target);
- (b)  $(0.9 \times \mathbf{A} \times 4) = \mathbf{B}^2$  (the number of completed immunisation courses needed to meet the 90% target).

8.5 Health Boards will then need to calculate which, if any, target was achieved. To do this, a Health Board will also need from the contractor the number of children in the cohort of children in respect of whom the calculation is to be made who, by the end of the quarter to which the calculation relates, have completed immunisation courses in each of the three disease groups (**C1** + **C2** + **C3**). In this section 8, **C1** is the number of children in the cohort who have completed the immunisation course in respect of the diseases referred to in paragraph 8.3(b)(i); **C2** is the number of children in the cohort who have completed the immunisation course in respect of the diseases referred to in paragraph 8.3(b)(ii) and **C3** is the number of children in the cohort who have completed the immunisation course in respect of the diseases referred to in paragraph 8.3(b)(iii). Only completed immunisation courses (whether or not carried out by the contractor) are to count towards the determination of whether or not the targets are achieved. No adjustment is to be made for exception reporting. A calculation (which provides for an additional weighting factor of 2 to be given to immunisation courses in respect of the diseases referred to in paragraph 8.3(b)(i)) is then to be made of whether or not the targets are achieved–

- (a) if  $(\mathbf{C1} \times 2) + \mathbf{C2} + \mathbf{C3} \geq \mathbf{B}^1$ , then the 70% target is achieved; and
- (b) if  $(\mathbf{C1} \times 2) + \mathbf{C2} + \mathbf{C3} \geq \mathbf{B}^2$ , then the 90% target is achieved.

8.6 Next the Health Board will need to calculate the number of the completed immunisation courses, notified under paragraph 8.11(b)(ii), that the contractor can use to count towards achievement of the targets (**D**). To do this, the contractor will need

to provide the Health Board with a breakdown of how many immunisation courses in each disease group were completed before the end of the quarter to which the calculation relates by a completing immunisation administered, within the NHS (and not necessarily during the quarter to which the calculation relates), by-

(a) the Contractor;

(b) another GMS contractor as part of primary medical services to a patient who was at that time registered with that contractor (where the term “GMS contractor” includes a contractor providing services under section 28Q of the 1977 Act, a contractor providing services under section 17J of the National Health Services (Scotland) Act 1978 or a contractor providing services under Article 57 of the Health and Personal Social Services (Northern Ireland) Order 1972);

(c) a PMS contractor as part of primary medical services to a patient who was at that time registered with that contractor (where the term “PMS Contractor ” includes a contractor providing services under section 28C of the 1977 Act, a contractor providing services under section 17C of the National Health Services (Scotland) Act 1978 and a contractor providing services under Article 15B of the Health and Personal Social Services (Northern Ireland) Order 1972);

(d) an Alternative Provider Medical Services contractor (“APMS contractor”) as part of primary medical services to a patient who was at that time registered with that contractor (where the term “APMS contractor” includes a contractor providing services under arrangements made under section 16CC(2)(b) of the 1977 Act, a contractor providing services under arrangements made under section 2C(2) of the National Health Services (Scotland) Act 1978 and a contractor providing services under arrangements made under Article 56(2)(b) of the Health and Personal Social Services (Northern Ireland) Order 1972); or

(e) a Primary Care Trust Medical Services practice (“PCTMS practice”) as part of primary medical services to a patient who was at that time registered with that practice (where the term “a PCTMS practice” includes a practice providing services under arrangements made under section 16CC(2)(a) of the 1977 Act and a practice providing services under arrangements made under Article 56(2)(a) of the Health and Personal Social Services (Northern Ireland) Order 1972 (such arrangements in Northern Ireland being referred to as Health and Social Services Board Medical Services)),

For the purposes of this paragraph 8.6 and paragraph 8.7, an immunisation course is considered as being completed when the final immunisation needed to complete the immunisation course (the “completing immunisation”) is administered.

8.7 Once the Health Board has that information, **(D)** is to be calculated as follows—

$$\begin{array}{r}
 \mathbf{C1} \times 2 \text{ minus } \mathbf{E1} \times 2 \\
 + \quad \mathbf{C2} \text{ minus } \mathbf{E2} \\
 + \quad \mathbf{C3} \text{ minus } \mathbf{E3} \\
 \hline
 = \quad \quad \quad \mathbf{D}
 \end{array}$$

For these purposes—

- (a) **(E<sup>x</sup>)** is the number of completed immunisation courses in each disease group where the completing immunisation was carried out other than by a contractor or practice of the type specified in, and under the circumstances specified in, any of the paragraphs 8.6(a) to (e) (e.g. for the diseases referred to in paragraph 8.3(b)(i), **E1**);
- (b) **(C<sup>x</sup>)** is the number of children in the cohort of children in respect of whom the calculation is to be made who have completed the immunisation course in respect of a particular disease group (e.g. for the diseases referred to in paragraph 8.3(b)(i), **C1**),
- (c) in the case of the disease group referred to in paragraph 8.3(b)(i), the value of  $(C1 \times 2) - (E1 \times 2)$  can never be greater than  $(A \times 2) \times 0.7$  or  $0.9$  (depending on which target is achieved); where it is, it is treated as the result of  $(A \times 2) \times 0.7$  or, as the case may be,  $0.9$ ; and
- (d) in any other case the value of  $C^x - E^x$  can never be greater than  $A \times 0.7$  or  $0.9$  (depending on which target achieved); where it is, it is treated as the result of:  $A \times 0.7$  or as the case may be  $0.9$ .

8.8 The maximum amounts payable to a contractor will depend on the number of children aged two whom it is under a contractual obligation to include in its Childhood Immunisations Scheme Register on the first day of each quarter compared with the average UK number of such children per 5000 population, which is 61. The maximum amounts payable to the contractor (**F**) are therefore to be calculated as follows—

- (a) where the 70% target is achieved:  $(F^1) = \frac{A}{61} \times \text{£}722.32$ ; or
- (b) where the 90% target is achieved:  $(F^2) = \frac{A}{61} \times \text{£}2,166.97$

8.9 The Quarterly TYOIP payable to the contractor is thereafter calculated as a proportion of the maximum amounts payable as follows–

$$F^1 \text{ or } F^2 \times \frac{D}{B^1 \text{ or } B^2} = \text{Quarterly TYOIP}$$

8.10 The amount payable as a Quarterly TYOIP is to fall due on the last day of the quarter the contractor is seeking payment (i.e. at the end of the quarter after the last quarter in which immunisations were carried out that could count towards the targets). However, if the contractor delays providing the information the Health Board needs to calculate its Quarterly TYOIP beyond the Health Board’s cut-off date for calculating quarterly payments, the amount is to fall due at the end of the next quarter (that is, just under nine months after the cohort was established. No Quarterly TYOIP is payable if the contractor provides the necessary information more than four months after the final date for immunisations which could count towards the payment. The following table summarises the timetable in accordance with which TYOIPs will be made, unless the information the Health Board needs to calculate the payment is supplied late.

<i>Quarter in which the payment is made</i>	<i>Date the cohort of children is established</i>	<i>Final date for which immunisations count towards the payment</i>	<i>Final date for submitting returns to the Health Board</i>	<i>Date the payment falls due</i>
First quarter of the financial year	1 <sup>st</sup> April	31st March	Date in September set by the Health Board	30 <sup>th</sup> June
Second quarter of the financial year	1 <sup>st</sup> July	30 <sup>th</sup> June	Date in December set by the Health Board	30 <sup>th</sup> September
Third quarter of the financial year	1 <sup>st</sup> October	30 <sup>th</sup> September	Date in March set by the Health Board	31 <sup>st</sup> December
Fourth quarter of the financial year	1 <sup>st</sup> January	31 <sup>st</sup> December	Date in June set by the Health Board	31 <sup>st</sup> March

***Conditions attached to Quarterly Two-Year-Olds Immunisation Payments***

8.11 Quarterly TYOIPs, or any part thereof, are only payable if the contractor satisfies the following conditions–

- (a) the contractor must meet its obligations under its Childhood Immunisations Scheme plan;
- (b) the contractor must make available to the Health Board sufficient information to enable the Health Board to calculate the contractor’s

Quarterly TYOIP. In particular, the contractor must supply the following figures–

- (i) the number of two-year-olds whom it is under a contractual obligation to include in its Childhood Immunisations Scheme Register on the first day of the quarter in respect of which a payment is claimed,
  - (ii) how many of those two-year-olds have completed each of the recommended immunisation courses (ie that have been recommended nationally and by the World Health Organisation) for protection against the disease groups referred to in paragraph 8.3(b) by the end of the quarter in respect of which a payment is claimed, and
  - (iii) of those completed immunisation courses, how many were carried out by a contractor or practice of a type specified in, and under the circumstances specified in, any of the paragraphs 8.6 (a) to (e)); and
- (c) all information supplied pursuant to or in accordance with this paragraph must be accurate.

8.12 If the contractor breaches any of these conditions, the Health Board may, in appropriate circumstances, withhold payment of all or part of a Quarterly TYIOP that is otherwise payable.

### ***Target payments in respect of five-year-olds***

8.13 Health Boards must pay to a contractor under its GMS contract a Quarterly Five-Year-Olds Immunisation Payment (“Quarterly FYOIP”) if it qualifies for that payment. A contractor qualifies for that payment if–

- (a) as part of its GMS contract the contractor and the Health Board have agreed a Childhood Immunisation Scheme plan; and
- (b) as regards the cohort of children established on that day, who are registered with the contractor and who are aged five (i.e. who have passed their fifth birthday but not yet their sixth), by the end of that quarter at least 70%, for the lower payment, or at least 90%, for the higher payment, have received all the recommended reinforcing doses (ie those that have been recommended nationally and by the World Health Organisation for protection against diphtheria, tetanus, pertussis and poliomyelitis).

### ***Calculation of Quarterly Five-Year-Olds Immunisation Payment***

8.14 Health Boards will need to determine the number of completed immunisation courses that are required in order to meet either the 70% or the 90% target. To do this, the contractor will need to provide the Health Board with the number of five-year-

olds (**A**) whom it is under a contractual obligation to include in its Childhood Immunisations Scheme Register on the first day of the quarter in respect of which the contractor is seeking payment (this is the cohort of children in respect of whom the calculation is to be made), and then the Health Board must make the following calculations–

- (a)  $(0.7 \times \mathbf{A}) = \mathbf{B}^1$  (the number of completed booster courses needed to meet the 70% target; and
- (b)  $(0.9 \times \mathbf{A}) = \mathbf{B}^2$  (the number of completed booster courses needed to meet the 90% target).

8.15 Health Boards will then need to calculate which, if any, target was achieved. To do this, a Health Board will also need from the contractor the number of children in the cohort of children in respect of whom the calculation is to be made who, by the end of the quarter to which the calculation relates, have completed the booster courses required (**C**). Only completed booster courses (whether or not carried out by the contractor) are to count towards the determination of whether or not the target was achieved. No adjustment is to be made for exception reporting. A calculation is then to be made of whether or not the targets are achieved–

- (a) if  $\mathbf{C} \geq \mathbf{B}^1$ , then the 70% target is achieved; and
- (b) if  $\mathbf{C} \geq \mathbf{B}^2$ , then the 90% target is achieved.

8.16 Next the Health Board will need to calculate the number of the completed courses, notified under paragraph 8.21(b)(ii), that the contractor can use to count towards achievement of the targets (**D**), the initial value of which is (**C**) minus the number of children whose completed courses were not carried out by a contractor or practice of a type specified in, and under the circumstances specified in, any of the sub-paragraphs (a) to (e) below. To do this, the contractor will need to provide the Health Board with a breakdown of how many of the completed courses were carried out before the end of the quarter to which the calculation relates by a completing course administered, within the NHS (and not necessarily during the quarter to which the calculation relates), by-

- (a) the Contractor;
- (b) another GMS contractor as part of primary medical services to a patient who was at that time registered with that contractor (where the term “GMS contractor” includes a contractor providing services under section 28Q of the 1977 Act, a contractor providing services under section 17J of the National Health Services (Scotland) Act 1978 or a contractor providing services under Article 57 of the Health and Personal Social Services (Northern Ireland) Order 1972);
- (c) a PMS contractor as part of primary medical services to a patient who was at that time registered with that contractor (where the term “PMS Contractor” includes a contractor providing services under section 28C of the 1977 Act, a contractor providing services under section 17C of the National Health

Services (Scotland) Act 1978 and a contractor providing services under Article 15B of the Health and Personal Social Services (Northern Ireland) Order 1972);

(d) an Alternative Provider Medical Services contractor (“APMS contractor”) as part of primary medical services to a patient who was at that time registered with that contractor (where the term “APMS contractor” includes a contractor providing services under arrangements made under section 16CC(2)(b) of the 1977 Act, a contractor providing services under arrangements made under section 2C(2) of the National Health Services (Scotland) Act 1978 and a contractor providing services under Article 56(2)(b) of the Health and Personal Social Services (Northern Ireland) Order 1972); or

(e) a Primary Care Trust Medical Services practice (“PCTMS practice”) as part of primary medical services to a patient who was at that time registered with that practice (where the term “a PCTMS practice” includes a practice providing services under arrangements made under section 16CC(2)(a) of the 1977 Act and a practice providing services under Article 56(2)(a) of the Health and Personal Social Services (Northern Ireland) Order 1972 (such arrangements in Northern Ireland being referred to as Health and Social Services Board Medical Services)).

8.17 If  $D > B^1$  or  $B^2$  (depending on the target achieved), then ( $D$ ) is adjusted to equal the value of ( $B^1$ ) or ( $B^2$ ) as appropriate.

8.18 The maximum amounts payable to a contractor will depend on the number of children aged five whom it is under a contractual obligation to include in its Childhood Immunisations Scheme Register on the first day of each quarter compared with the average UK number of such children per 5000 population, which is 57. The maximum amounts payable to the contractor ( $E$ ) are therefore to be calculated as follows–

- (a) where the 70% target is achieved:  $E^1 = \frac{A}{57} \times \text{£}223.73$  or
- (b) where the 90% target is achieved:  $E^2 = \frac{A}{57} \times \text{£}671.21$

8.19 The Quarterly FYOIP payable to the contractor is thereafter calculated as a proportion of the maximum amounts payable as follows–

$$E^1 \text{ or } E^2 \times \frac{D}{B^1 \text{ or } B^2} = \text{Quarterly FYOIP}$$

8.20 The amount payable as a Quarterly FYOIP is to fall due on the last day of the quarter the contractor is seeking payment (ie at the end of the quarter after the last quarter in which completed courses were carried out that could count towards the targets). However, if the contractor delays providing the information the Health Board needs to calculate its Quarterly FYOIP beyond the Health Board’s cut-off date for calculating quarterly payments the amount is to fall due at the end of the next quarter (that is, just under nine months after the cohort was established). No



Quarterly FYOIP is payable if the contractor provides the necessary information more than four months after the final date for immunisations which could count towards the payment. The table in paragraph 8.10 summarises the timetable in accordance with which FYOIPs will be made, unless the information the Health Board needs to calculate the payment is supplied late.

***Conditions attached to Quarterly Five-Year-Olds Immunisation Payments***

8.21 Quarterly FYOIPs, or any part thereof, are only payable if the contractor satisfies the following conditions–

- (a) the contractor must meet its obligations under its Childhood Immunisation Scheme plan;
- (b) the contractor must supply to the Health Board with sufficient information to enable the Health Board to calculate the contractor’s Quarterly FYOIP. In particular, the contractor must supply the following figures–
  - (i) the number of five-year-olds whom it is under a contractual obligation to include in its Childhood Immunisations Scheme Register on the first day of each quarter in respect of which a payment is claimed,
  - (ii) how many of those five-year-olds have received the complete course of recommended reinforcing doses (ie that have been recommended nationally and by the World Health Organisation) for protection against diphtheria, tetanus, pertussis and poliomyelitis by the end of the quarter in respect of which a payment is claimed, and
  - (iii) of those completed courses, how many were carried out by a contractor or practice of a type specified in, and under the circumstances specified in, any of the paragraphs 8.16 (a) to (e); and
- (c) all information supplied pursuant to or in accordance with this paragraph must be accurate.

8.22 If the contractor breaches any of these conditions, the Health Board may, in appropriate circumstances, withhold payment of all or part of a Quarterly FYOIP that is otherwise payable.

8.23 Contractors may use the data held on SIRS, or any equivalent system, when providing relevant information to Health Boards.

## PART 4

### PAYMENTS FOR SPECIFIC PURPOSES

#### **8A. Pneumococcal Vaccination and Hib/MenC Booster Vaccination**

8A.1 Changes were introduced to the routine childhood immunisation programme with effect from 4th September 2006. Details of those changes, which relate to the introduction of pneumococcal vaccine into the routine childhood immunisation programme, changes to the schedule for the Meningitis C (Men C) and Heamophilus influenzae type B (HiB) vaccinations, and a pneumococcal vaccination catch-up programme for children aged under 2 years, were set out in a letter dated 12th July 2006 from the Chief Medical Officer, the Chief Nursing Officer and the Chief Pharmaceutical Officer. The provisions contained in Annex 1 and Annex 2 of that letter are set out in Annex I to this SFE.

8A.2 Childhood immunisation and pre-school booster services are classified as Additional Services. This Section makes provision in respect of payments to be made in respect of the administration by a contractor, which is contracted to provide the childhood immunisation and pre-school booster Additional Service, of the pneumococcal conjugate vaccine (PCV) and the combined Hib and Men C booster vaccine (Hib/MenC) as part of the routine childhood immunisation schedule and in certain non-routine cases.

8A.3 The provisions of this section apply with effect from 4th September 2006.

8A.4 References in this Section to the age of a child expressed in months are references to calendar months. Where reference is made to a vaccination being administered at or around a certain age, this is an indication of the recommended schedule for administration of the vaccine contained in the provisions as set out in Annex I to this SFE. The specific timing of the administration of the vaccination, which should be within the parameters of the recommended schedule, is a matter for the clinical judgement of the relevant health care professional.

#### ***Payment for administration of PCV vaccinations and Hib/MenC vaccinations as part of the routine childhood immunisation schedule***

8A.5 The Health Board must pay to a contractor who qualifies for the payment, a payment of £15.02 in respect of each child registered with the contractor—

- (a) who has received, as part of their routine childhood immunisation schedule, all four of the vaccinations set out in the table at paragraph 8A.7, namely the series of three PCV vaccinations to be administered at two months, four months and around 13 months, and the Hib/MenC booster vaccination which is to be administered at around 12 months; and

- (b) in respect of whom the contractor administered the final completing vaccination.

8A.6 For the purpose of paragraph 8A.5(b), the final completing vaccination means the third in the series of three PCV vaccinations which is scheduled, in the table at paragraph 8A.7, to be administered at around 13 months.

8A.7 The table below sets out the schedule for the administration of the PCV and the Hib/MenC vaccinations as part of the routine childhood immunisation schedule.

When to immunise	What is given	How vaccine is given
Two months old	Pneumococcal (PCV)	One injection
Four months old	Pneumococcal (PCV)	One injection
Around 12 months	Haemophilus influenzae type b, Meningitis C (Hib/MenC)	One injection
Around 13 months	Pneumococcal (PCV)	One injection

***Payment for administration of PCV vaccinations other than as part of the routine childhood immunisation schedule***

8A.8 The Health Board must pay to a contractor who qualifies for the payment, a payment of £15.02 in respect of each child registered with the contractor who has received the PCV vaccination in any of the circumstances set out in paragraphs 8A.10 to 8A.14 and in respect of whom the contractor administered the final completing vaccination..

***Children at increased risk of pneumococcal infection***

8A.9 The table below sets out what are, for the purposes of this Section, the specific pneumococcal clinical risk groups for children.

Clinical risk group	Examples (decision based on clinical judgement)
Asplenia or dysfunction of the spleen	This includes conditions such as homozygous sickle cell disease and coeliac syndrome that may lead to splenic dysfunction.
Chronic respiratory disease	This includes chronic obstructive pulmonary disease (COPD), including chronic bronchitis and emphysema; and such conditions as bronchiectasis, cystic fibrosis, interstitial lung fibrosis, pneumoconiosis and bronchopulmonary dysplasia (BPD). Children with respiratory conditions caused by aspiration, or a neuromuscular disease (e.g. cerebral palsy) with a risk of aspiration. Asthma is not an indication, unless continuous or frequently repeated use of systemic steroids (as defined in Immunosuppression below) is needed.

Chronic heart disease	This includes those requiring regular medication and/or follow-up for ischaemic heart disease, congenital heart disease, hypertension with cardiac complications, and chronic heart failure.
Chronic renal disease	This includes nephrotic syndrome, chronic renal failure, renal transplantation.
Chronic liver disease	This includes cirrhosis, biliary atresia, chronic hepatitis
Diabetes (requiring insulin or oral hypoglycaemic drugs)	This includes type I diabetes requiring insulin or type 2 diabetes requiring oral hypoglycaemic drugs. It does not include diabetes that is diet controlled.
Immunosuppression	Due to disease or treatment, including asplenia or splenic dysfunction and HIV infection at all stages. Patients undergoing chemotherapy leading to immunosuppression. Individuals treated with or likely to be treated with systemic steroids for more than a month at a dose equivalent to prednisolone 20mg or more per day (any age), or for children under 20kg, a dose of $\geq 1$ mg/kg/day. Some immunocompromised patients may have a suboptimal immunological response to the vaccine.
Individuals with cochlear implants	It is important that immunisation does not delay the cochlear implantation. Where possible, pneumococcal vaccination should be completed at least 2 weeks prior to surgery to allow a protective immune response to develop. In some cases it will not be possible to complete the course prior to surgery. In this instance, the course should be started at any time prior to or following surgery and completed according to the immunisation schedule.
Individuals with Cerebrospinal fluid leaks	This includes leakage of cerebrospinal fluid such as following trauma or major skull surgery.

8A.10 Where a child who is in any of the pneumococcal clinical risk groups set out in the table in paragraph 8A.9 presents late for vaccination (that is, not in accordance with the routine schedule set out in paragraph 8A.7), and -

- (a) consequently cannot receive, and has not received, the four vaccinations referred to in paragraph 8A.5(a) in accordance with the routine schedule set out in the table in paragraph 8A.7; but
- (b) who nevertheless still presents in time to enable him to receive, and did receive, two doses of PCV before the age of 12 months, the Hib/MenC booster at around the age of 12 months and a third dose of PCV at around the age of 13 months,

the Health Board must pay to the contractor administering the final completing vaccination a payment of £15.02 in respect of that child. The third dose of PCV is considered the final completing vaccination for this purpose.

8A.11 Where a child over the age of 12 months but under the age of 5 years and who is in any of the clinical risk groups set out in the table in paragraph 8A.9 presents late for vaccination (that is, not in accordance with the routine schedule set out in paragraph 8A.7), and–

(a) consequently cannot receive, and has not received, two doses of PCV before the age of 12 months, the Hib/Men C booster at around the age of 12 months and a third dose of PCV at around the age of 13 months; but

(b) who nevertheless receives either a single dose of PCV or, if he has asplenia, splenic dysfunction or is immunocompromised, two doses of PCV, the second of which is administered two months after the first dose,

the Health Board must pay to the contractor administering the final completing vaccination a payment of £15.02 in respect of that child. The single dose of PCV or, in the case of a child where a second dose of PCV is required, the second dose of PCV is considered the final completing vaccination for this purpose.

***Children over the age of 13 months but under 5 years who have previously had invasive pneumococcal disease***

8A.12 Where a child who is over 13 months but under 5 years and who has previously had invasive pneumococcal disease receives a single dose of PCV in accordance with the recommendation contained in paragraph 6 of Annex 1 of the provisions set out at Annex I to this SFE, the Health Board must pay to the contractor administering the final completing vaccination a payment of £15.02 in respect of that child, unless a payment is otherwise payable for that same final completing vaccination under paragraph 8A.11, or 8A.14. The single dose of PCV is considered the final completing vaccination for this purpose.

***Children with an unknown or incomplete vaccination status***

8A.13 Where a child who has an unknown or incomplete vaccination status receives vaccinations sufficient to ensure that he has received two doses of PCV before the age of 12 months, the Hib/MenC booster at around the age of 12 months and a third dose of PCV at around the age of 13 months, the Health Board must pay to the contractor administering the final completing vaccination a payment of £15.02 in respect of that child. The third dose of PCV is considered the final completing vaccination for this purpose.

8A.14 Where a child who has an unknown or incomplete vaccination status and is too old to be able to receive two doses of PCV before the age of 12 months, the Hib/MenC booster at around the age of 12 months and a third dose at around the age of 13 months, receives a single dose of PCV prior to the age of 24 months, the Health Board must pay to the contractor who administers the final completing vaccination a

payment of £15.02 in respect of that child. The single dose of PCV is considered the final completing vaccination for this purpose

### ***Eligibility for payment***

8A.15 A contractor is only eligible for a payment under this Section in circumstances where the following conditions are met–

- (a) the contractor is contracted to provide the childhood immunisation and pre-school booster Additional Service;
- (b) the child in respect of whom the payment is claimed was on the contractor’s list of registered patients at the time the final completing vaccination was administered;
- (c) the contractor administers the final completing vaccination to the child in respect of whom the payment is claimed;
- (d) subject to sub-paragraph (e), the child in respect of whom the payment is claimed is aged around 13 months when the final completing vaccination is administered;
- (e) in the case of payments in respect of vaccinations administered in accordance with paragraphs 8A.11 or 8A.12, the child must be under 5 years when the final completing vaccination is administered and in the case of vaccinations administered in accordance with paragraph 8A.14, the child must be under 2 years when the final completing vaccination is administered;
- (f) the contractor does not receive any payment from any other source in respect of any of the series of three PCV vaccinations and the Hib/MenC booster vaccination set out in the table at paragraph 8A.7 or in respect of any vaccination administered under any of the circumstances set out in paragraphs 8A.10 to 8A.14 of this Section (if he does receive any such payment in respect of any child from any other source, the Health Board must give serious consideration to recovering any payment made under this Section in respect of that child pursuant to paragraph 21.1(a)); and
- (g) the contractor submits the claim within 6 months of administering the final completing vaccination.

8A.16 The Health Board may set aside the requirement that the contractor submit the claim within 6 months of administering the final completing vaccination if it considers it reasonable to do so.

8A.17 The contractor is not entitled to payment of more than £15.02 in respect of any child under this Section, other than where–

- (a) the contractor claims for payment for a final completing vaccination administered under the circumstances set out in paragraph 8A.12, and
- (b) by virtue of that paragraph, the contractor is entitled to a payment under that paragraph, irrespective of any previous payment made in respect of that child under the provisions of this Section.

***Claims for payment***

8A.18 The contractor is to submit claims in respect of final completing vaccinations after they have been administered. The amount payable is to fall due quarterly on the last day of the quarter after the last quarter in which the vaccinations were carried out, in-line with the target Childhood Immunisations.

8A.19 Health Boards must ensure that the receipt and payment in respect of any claims are properly recorded and that each such claim has a clear audit trail.

***Conditions attached to payment***

8A.20 A payment under the provisions of this Section is only payable if the contractor satisfies the following conditions—

- (a) the contractor must supply the Health Board with the following information in respect of each child for which a payment is claimed—
  - (i) the name of the child;
  - (ii) the CHI number of the child;
  - (iii) subject to paragraph (iv) below, confirmation that the child has received three doses of PCV and one dose of Hib/MenC in accordance with the table at paragraph 8A.7;
  - (iv) if the claim is made in the circumstances set out in paragraph 8A.11, 8A.12 or 8A.14, confirmation that all required vaccinations have been administered, and
  - (v) the date of the final completing vaccination, which must have been administered by the contractor,
 but where a parent or carer objects to details of the child’s name being supplied to the Health Board, the contractor need not supply such information to the Health Board but must supply the child’s CHI number;
- (b) the contractor must provide appropriate information and advice to the parent or carer of the child, and, where appropriate, also to the child, about pneumococcal vaccinations and the Hib/MenC booster vaccination;
- (c) the contractor must record in the child’s records, kept in accordance with paragraph 66 of Schedule 5 to the 2004 Regulations, any refusal of an offer of a pneumococcal vaccination or a Hib/MenC Booster vaccination;

- (d) where a pneumococcal vaccination or a Hib/MenC booster vaccination is administered, the contractor must record in the child's records, kept in accordance with paragraph 66 of Schedule 5 to the 2004 Regulations, those matters set out in paragraph 5(2)(d) of Schedule 1 to the 2004 Regulations;
- (e) the contractor must ensure that any health care professional who performs any clinical service in connection with the administration of the vaccine has such clinical experience and training as are necessary to enable him to properly perform such services and that such health care professionals are trained in the recognition and initial treatment of anaphylaxis;
- (f) the contractor must make available to the Health Board any information which the Health Board does not have but needs, and the contractor either has or could be reasonably expected to obtain, in order to form its opinion on whether the contractor is eligible for payment under the provisions of this Section;
- (g) the contractor must make any returns required of it (whether computerised or otherwise) to the Practitioner Services Division (PSD) of NHS National Services Scotland, and do so promptly and fully; and
- (h) all information provided pursuant to or in accordance with this paragraph must be accurate.

8A.21 If the contractor breaches any of these conditions, the Health Board may, in appropriate circumstances, withhold payment of any, or any part of, the payment due under this Section.



## **9. Payments for locums covering maternity, paternity and adoption leave**

9.1 Employees of contractors will have rights to time off for ante-natal care, maternity leave, paternity leave, adoption leave and parental leave, if they satisfy the relevant entitlement conditions under employment legislation for those types of leave. The rights of partners in partnerships to these types of leave is a matter for their partnership agreement.

9.2 If an employee or partner who takes any such leave is a performer under a GMS contract, the contractor may need to employ a locum to maintain the level of services that it normally provides. Even if the Health Board is not directed in this SFE to pay for such cover, it may do so as a matter of discretion. However, if–

- (a) the performer is a GP performer; and
- (b) the leave is ordinary maternity, paternity leave or ordinary adoption leave,

the contractor may be entitled to payment of, or a contribution towards, the costs of locum cover under this SFE.

### ***Entitlement to payments for covering ordinary maternity, paternity and ordinary adoption leave***

9.3 In any case where a contractor actually and necessarily engages a locum (or more than one such person) to cover for the absence of a GP performer on ordinary maternity leave, paternity leave or ordinary adoption leave, and–

- (a) the leave of absence is for more than one week (the maximum periods are: 26 weeks for ordinary maternity leave and for ordinary adoption leave for the parent who is the main care provider; and 2 weeks for paternity leave and for adoption leave for the parent who is not the main care provider);
- (b) the performer on leave is entitled to that leave either under–
  - (i) statute,
  - (ii) a partnership agreement or other agreement between the partners of a partnership, or
  - (iii) a contract of employment, provided that the performer on leave is entitled under their contract of employment to be paid their full salary by the contractor during their leave of absence;

- (c) the locum is not a partner or shareholder in the contractor, or already an employee of the contractor, unless the performer on leave is a job-sharer; and
- (d) the contractor is not also claiming another payment for locum cover in respect of the performer on leave pursuant to this Part,

then subject to the following provisions of this Section, the Health Board must provide financial assistance to the contractor under its GMS contract in respect of the cost of engaging that locum (which may or may not be the maximum amount payable, as set out in paragraph 9.5).

9.4 It is for the Health Board to determine whether or not it is or was in fact necessary to engage the locum, or to continue to engage the locum, but it is to have regard to the following principles–

- (a) it should not normally be considered necessary to employ a locum if the Health Board has offered to provide the locum cover itself and the contractor has refused that offer without good reason;
- (b) it should not normally be considered necessary to employ a locum if the performer on leave had a right to return but that right has been extinguished; and
- (c) it should not normally be considered necessary to employ a locum if the contractor has engaged a new employee or partner to perform the duties of the performer on leave and it is not carrying a vacancy in respect of another position which the performer on leave will fill on his return.

### ***Ceilings on the amounts payable***

9.5 The maximum amount payable under this Section by the Health Board in respect of locum cover for a GP performer is–

- (a) in respect of the first two weeks for which the Health Board provides reimbursement in respect of locum cover, £982.92 per week, and
- (b) in respect of any week thereafter for which the Health Board provides reimbursement in respect of locum cover, £1506.15 per week.

### ***Payment arrangements***

9.6 The contractor is to submit claims for costs actually incurred after they have been incurred, at a frequency to be agreed between the Health Board and the contractor, or if agreement cannot be reached, within 14 days of the end of month during which the costs were incurred. Any amount payable falls due at the end of the month after the claim is submitted.

***Conditions attached to the amounts payable***

9.7 Payments under this Section, or any part thereof, are only payable if the contractor satisfies the following conditions—

- (a) if the leave of absence is maternity leave, the contractor must supply the Health Board with a certificate of expected confinement as used for the purposes of obtaining statutory maternity pay, or a private certificate providing comparable information;
- (b) if the leave of absence is for paternity leave, the contractor must supply the Health Board with a letter written by the GP performer confirming prospective fatherhood and giving the date of expected confinement;
- (c) if the leave of absence is for adoption leave, the contractor must supply the Health Board with a letter written by the GP performer confirming the date of the adoption and the name of the main care provider, countersigned by the appropriate adoption agency;
- (d) the contractor must, on request, provide the Health Board with written records demonstrating the actual cost to it of the locum cover;
- (e) once the locum arrangements are in place, the contractor must inform the Health Board—
  - (i) if there is to be any change to the locum arrangements, or
  - (ii) if, for any other reason, there is to be a change to the contractor's arrangements for performing the duties of the performer on leave,

at which point the Health Board is to determine whether it still considers the locum cover necessary.

9.8 If the contractor breaches any of these conditions, the Health Board may, in appropriate circumstances, withhold payment of any sum otherwise payable under this Section.

## 10. Payments for locums covering sickness leave

10.1 Employees of contractors will, if they qualify for it, be entitled to statutory sick pay for 28 weeks of absence on account of sickness in any three years. The rights of partners in partnership agreements to paid sickness leave is a matter for their partnership agreement.

10.2 If an employee or partner who takes any sickness leave is a performer under a GMS contract, the contractor may need to employ a locum to maintain the level of services that it normally provides. Even if the Health Board is not directed in this SFE to pay for such cover, it may do so as a matter of discretion – and indeed, it may also provide locum support for performers who are returning from sickness leave or for those who are at risk of needing to go on sickness leave. It should in particular consider exercising its discretion–

- (a) where there is an unusually high rate of sickness in the area where the performer performs services; or
- (b) to support contractors in rural areas where the distances involved in making home visits make it impracticable for a GP performer returning from sickness leave to assume responsibility for the same number of patients for which he previously had responsibility.

### *Entitlement to payments for covering sickness leave*

10.3 In any case where a contractor actually and necessarily engages a locum (or more than one such person) to cover for the absence of a GP performer on sickness leave, and–

- (a) the leave of absence is for more than one week;
- (b) if the performer on leave is employed by the contractor, the contractor must–
  - (i) be required to pay statutory sick pay to that performer, or
  - (ii) be required to pay the performer on leave his full salary during absences on sick leave under his contract of employment.
- (c) if the GP performer’s absence is as a result of an accident, the contractor must be unable to claim any compensation from whoever caused the accident towards meeting the cost of engaging a locum to cover for the GP performer during the performer’s absence. But if such compensation is payable, the Health Board may loan the contractor the cost of the locum, on the condition that the loan is repaid when the compensation is paid unless–
  - (i) no part of the compensation paid is referable to the cost of the locum, in which case the loan is to be considered a

reimbursement by the Health Board of the costs of the locum which is subject to the following provisions of this Section, or

- (ii) only part of the compensation paid is referable to the cost of the locum, in which case the liability to repay shall be proportionate to the extent to which the claim for full reimbursement of the costs of the locum was successful;
- (d) the locum is not a partner or shareholder in the contractor, or already an employee of the contractor, unless the performer on leave is a job-sharer; and
- (e) the contractor is not already claiming another payment for locum cover in respect of the performer on leave pursuant to this Part,

then subject to the following provisions of this Section, the Health Board must provide financial assistance to the contractor under its GMS contract in respect of the cost of engaging a locum (which may or may not be the maximum amount payable, as set out in paragraph 10.5).

10.4 It is for the Health Board to determine whether or not it was in fact necessary to engage the locum, or to continue to engage the locum, but it is to have regard to the following principles–

- (a) it should not normally be considered necessary if the Health Board has offered to provide the locum cover itself and the contractor has refused that offer without good reason;
- (b) it should not normally be considered necessary to employ a locum if the performer on leave had a right to return but that right has been extinguished; and
- (c) it should not normally be considered necessary to employ a locum if the contractor has engaged a new employee or partner to perform the duties of the performer on leave and it is not carrying a vacancy in respect of another position which the performer on leave will fill on his return;
- (d) it should not normally be considered necessary for a contractor with two or more GP performers to engage a locum to replace a GP performer, unless the absence of the performer on leave leaves each of the other GP performers (*not including members of the Doctor's Retainer Scheme*) with average numbers of patients as follows–

<i>Absences lasting or expected to last</i>	<i>Full-time GP</i>	<i>Three-quarter-time GP</i>	<i>Half-time GP</i>
Not more than 2 weeks	3600+ patients	2700+ patients	1800+ patients
Not more than 6 weeks	3100+ patients	2325+ patients	1550+ patients
Longer than 6 weeks	2700+ patients	2025+ patients	1350+ patients

- (e) it should normally be considered necessary that a single-handed GP performer or a job-sharer fulfilling the role of a single-handed GP performer will need to be replaced, if they are on sickness leave, by a locum.

### ***Ceilings on the amounts payable***

10.5 The maximum amount payable under this Section by the Health Board in respect of locum cover for a GP performer is £982.92 per week.

10.6 However, the maximum periods in respect of which payments under this Section are payable in relation to a particular GP performer are—

- (a) 26 weeks for the full amount of the sum that the Health Board has determined is payable; and
- (b) a further 26 weeks for half the full amount of the sum the Health Board initially determined was payable.

10.7 In order to calculate these periods, a determination is to be made in respect of the first day of the GP performer's absence as to whether, in the previous 52 weeks, any amounts have been payable in respect of him under this Section or Section 10 of the 2004/5 SFE. If any amounts have been payable in those 52 weeks, the periods in respect of which they were payable are to be aggregated together. That aggregate period (whether or not it fact relates to more than one period of absence)—

- (a) if it is 26 weeks or less, is then to be deducted from the period referred to in paragraph 10.6(a); or
- (b) if it is more than 26 weeks, then 26 weeks of it is to be deducted from the period referred to paragraph 10.6(a) and the balance is to be deducted from the period referred to in paragraph 10.6(b).

Accordingly, if payments have been made in respect of locum cover for the GP performer for 32 weeks out of the previous 52 weeks, the remaining entitlement in respect of him is for a maximum of 20 weeks, and at half the full amount that the Health Board initially determined was payable.

### ***Payment arrangements***

10.8 The contractor is to submit to the Health Board claims for costs actually incurred during a month by the 10<sup>th</sup> of the following month, and any amount payable is to fall due on the same day of the following month that the contractor's Payable GSMP falls due.

### ***Conditions attached to the amounts payable***

10.9 Payments under this Section, or any part thereof, are only payable if the following conditions are satisfied—

- (a) the contractor must obtain the prior agreement of the Health Board to the engagement of the locum (but its request to do so must be determined as quickly as possible by the Health Board), including agreement as to the amount that is to be paid for the locum cover;
- (b) the contractor must, without delay, supply the Health Board with medical certificates in respect of each period of absence for which a request for assistance with payment for locum cover is being made;
- (c) the contractor must, on request, provide the Health Board with written records demonstrating the actual cost to it of the locum cover;
- (d) once the locum arrangements are in place, the contractor must inform the Health Board—
  - (i) if there is to be any change to the locum arrangements, or
  - (ii) if, for any other reason, there is to be a change to the contractor's arrangements for performing the duties of the performer on leave,

at which point the Health Board is to determine whether it still considers the locum cover necessary;

- (e) if the locum arrangements are in respect of a performer on leave who is or was entitled to statutory sick pay, the contractor must inform the Health Board immediately if it stops paying statutory sick pay to that employee;
- (f) the performer on leave must not engage in conduct that is prejudicial to his recovery; and
- (g) the performer on leave must not be performing clinical services for any other person, unless under medical direction and with the approval of the Health Board.

10.10 If any of these conditions are breached, the Health Board may, in appropriate circumstances, withhold payment of any sum otherwise payable under this Section.

## 11. Payments for locums to cover for suspended doctors

11.1 This section applies where a GP performer is on 1 April 2004 suspended from a medical or supplementary medical list or, on or after that day, is suspended from a performers list.

11.2 A GP performer who is suspended from a medical performers' list either–

- (a) on or after 1st April 2004; or
- (b) by virtue of being suspended from a performers list,

may be entitled to payments directly from the Health Board that suspended him. This is covered by a separate determination under regulation 15 (1) of the Performers List Regulations

### *Eligible cases*

11.3 In any case where a contractor–

- (a) either–
  - (i) is a sole practitioner who is suspended from his Health Board's medical performers list and is not in receipt of any financial assistance from his Health Board under section 17Q of the 1978 Act as a contribution towards the cost of the arrangements to provide primary medical services under his GMS contract during his suspension,
  - (ii) is paying a suspended GP performer–
    - (aa) who is a partner in the contractor, at least 90% of his normal monthly drawings (or a *pro rata* amount in the case of part months) from the partnership account, or
    - (bb) who is an employee of the contractor, at least 90% of his normal salary (or a *pro rata* amount in the case of part months), or
  - (iii) paid a suspended GP performer the amount mentioned in paragraph (ii)(aa) or (bb) for at least six months of his suspension, and the suspended GP performer is still a partner in or employee of the contractor;
- (b) actually and necessarily engages a locum (or more than one such person) to cover for the absence of the suspended GP performer;



- (c) the locum is not a partner or shareholder in the contractor, or already an employee of the contractor, unless the absent performer is a job-sharer; and
- (d) the contractor is not also claiming a payment for locum cover in respect of the absent performer under another Section in this Part,

then subject to the following provisions of this Section, the Health Board must provide financial assistance to the contractor under its GMS contract in respect of the cost of engaging that locum (which may or may not be the maximum amount payable, as set out in paragraph 11.5).

11.4 It is for the Health Board to determine whether or not it is or was in fact necessary to engage the locum, or to continue to engage the locum, but it is to have regard to the following principles–

- (a) it should not normally be considered necessary to employ a locum if the Health Board has offered to provide the locum cover itself and the contractor has refused that offer without good reason;
- (b) it should not normally be considered necessary to employ a locum if the absent performer had a right to return but that right has been extinguished; and
- (c) it should not normally be considered necessary to employ a locum if the contractor has engaged a new employee or partner to perform the duties of the absent performer and it is not carrying a vacancy in respect of another position which the absent performer will fill on his return.

### ***Ceilings on the amounts payable***

11.5 The maximum amount payable under this Section by the Health Board in respect of locum cover for a GP performer is £982.92 per week.

### ***Payment arrangements***

11.6 The contractor is to submit claims for costs actually incurred after they have been incurred, at a frequency to be agreed between the Health Board and the contractor, or if agreement cannot be reached, within 14 days of the end of month during which the costs were incurred. Any amount payable falls due at the end of the month after the claim is submitted.

### ***Conditions attached to the amounts payable***

11.7 Payments under this Section, or any part thereof, are only payable if the contractor satisfies the following conditions–

- (a) the contractor must, on request, provide the Health Board with written records demonstrating–

- (i) the actual cost to it of the locum cover, and
  - (ii) that it is continuing to pay the suspended GP performer at least 90% of his normal income before the suspension (i.e. his normal monthly drawings from the partnership account, his normal salary or a *pro rata* amount in the case of part months); and
- (b) once the locum arrangements are in place, the contractor must inform the Health Board—
- (i) if there is to be any change to the locum arrangements, or
  - (ii) if, for any other reason, there is to be a change to the contractor’s arrangements for performing the duties of the absent performer,

at which point the Health Board is to determine whether it still considers the locum cover necessary.

11.8 If the contractor breaches any of these conditions, the Health Board may, in appropriate circumstances, withhold payment of any sum otherwise payable under this Section.

## **12. Payments in respect of Prolonged Study Leave**

12.1 GP performers may be entitled to take Prolonged Study Leave, and in these circumstances, the contractor for whom they have been providing services under its GMS contract may be entitled to two payments–

- (a) an educational allowance, to be forwarded to the GP performer taking Prolonged Study Leave; and
- (b) the cost of, or a contribution towards the cost of, locum cover.

### ***Types of study in respect of which Prolonged Study Leave may be taken***

12.2 Payments may only be made under this Section in respect of Prolonged Study Leave taken by a GP performer where–

- (a) the study leave is for at least 10 weeks but not more than 12 months;
- (b) the educational aspects of the study leave have been approved by the local Director of Postgraduate GP Education, having regard to any guidance on Prolonged Study Leave that Directors of Postgraduate GP Education have agreed nationally; and
- (c) the Health Board has determined that the payments to the contractor under this Section in respect of the Prolonged Study Leave are affordable, having regard to the budgetary targets it has set for itself.

### ***The Educational Allowance Payment***

12.3 Where the criteria set out in paragraph 12.2 are met, in respect of each week for which the GP performer is on Prolonged Study Leave, the Health Board must pay the contractor an Educational Allowance Payment of £133.68, subject to the condition that where the contractor is aware of any change in circumstances that may affect its entitlement to the Education Allowance Payment, it notifies the Health Board of that change in circumstances.

12.4 If the contractor breaches the condition set out in paragraph 12.3, the Health Board may, in appropriate circumstances, withhold payment of any or any part of an Educational Allowance Payment that is otherwise payable.

### ***Locum cover in respect of doctors on Prolonged Study Leave***

12.5 In any case where a contractor actually and necessarily engages a locum (or more than one such person) to cover for the absence of a GP performer on Prolonged Study Leave, then subject to the following provisions of this Section, the Health Board must provide financial assistance to the contractor under its GMS contract in respect of the cost of engaging that locum (which may or may not be the maximum amount payable, as set out in paragraph 12.7).

12.6 It is for the Health Board to determine whether or not it was in fact necessary to engage the locum, or to continue to engage the locum, but it is to have regard to the following principles–

- (a) it should not normally be considered necessary to employ a locum if the Health Board has offered to provide the locum cover itself and the contractor has refused that offer without good reason;
- (b) it should not normally be considered necessary to employ a locum if the performer on leave had a right to return but that right has been extinguished; and
- (c) it should not normally be considered necessary to employ a locum if the contractor has engaged a new employee or partner to perform the duties of the performer on leave and it is not carrying a vacancy in respect of another position which the performer on leave will fill on his return.

12.7 The maximum amount payable under this Section by the Health Board in respect of locum cover for a GP performer is £982.92 per week.

#### ***Payment arrangements***

12.8 The contractor is to submit to the Health Board claims for costs actually incurred during a month at the end of that month, and any amount payable is to fall due on the same day of the following month that the contractor's Payable GSMP falls due.

#### ***Conditions attached to the amounts payable***

12.9 Payments in respect of locum cover under this Section, or any part thereof, are only payable if the following conditions are satisfied–

- (a) the contractor must obtain the prior agreement of the Health Board to the engagement of the locum (but its request to do so must be determined as quickly as possible by the Health Board), including agreement as to the amount that is to be paid for the locum cover;
- (b) the locum must not be a partner or shareholder in the contractor, or already an employee of the contractor, unless the performer on leave is a job-sharer;
- (c) the contractor must, on request, provide the Health Board with written records demonstrating the actual cost to it of the locum cover; and
- (d) once the locum arrangements are in place, the contractor must inform the Health Board–
  - (i) if there is to be any change to the locum arrangements, or

- (ii) if, for any other reason, there is to be a change to the contractor's arrangements for performing the duties of the performer on leave,

at which point the Health Board is to determine whether it still considers the locum cover necessary.

12.10 If any of these conditions are breached, the Health Board may, in appropriate circumstances, withhold payment of any sum in respect of locum cover otherwise payable under this Section.

## 13. Seniority Payments

13.1 Seniority Payments are payments to a contractor in respect of individual GP providers in eligible posts. They reward experience, based on years of Reckonable Service.

### *Eligible posts*

13.2 Contractors will only be entitled to a Seniority Payment in respect of a GP provider if the GP provider has served for at least two years in an eligible post, or for an aggregate of two years in more than one eligible post – part-time and full-time posts counting the same. The first date after the end of this two year period is the GP provider's qualifying date. For these purposes, a post is an eligible post–

- (a) in case of posts held prior to 1st April 2004, if the post-holder provided unrestricted general medical services and was eligible for a basic practice allowance under the Red Book; or
- (b) in the case of posts held on or after 1st April 2004, if the post-holder performs primary medical services and is-
  - (i) himself a GMS contractor (i.e. a sole practitioner),
  - (ii) a partner in a partnership that is a GMS contractor, or
  - (iii) a shareholder in a company limited by shares that is a GMS contractor.

### *Service that is Reckonable Service*

13.3 Work shall be counted as Reckonable Service if–

- (a) it is clinical service as a doctor within the NHS or service as a doctor in the public service health care system of another EEA Member State (including service in that system pre-Accession);
- (b) it is clinical service as a doctor or service as a medical officer within the prison service or the civil administration (which includes the Home Civil Service) of the United Kingdom, or within the prison service or the civil administration of another EEA Member State (including service in that prison service or the civil administration pre-Accession);
- (c) it is service as a medical officer–
  - (i) in the armed forces of an EEA Member State (including the United Kingdom) or providing clinical services to those forces in a civilian capacity (including service pre-Accession), or,

- (ii) in the armed forces under the Crown other than the United Kingdom armed forces or providing clinical services to those forces in a civilian capacity,

if accepted by the Health Board or endorsed by Scottish Ministers as Reckonable Service;

- (d) it is service with the Foreign and Commonwealth Office as a medical officer in a diplomatic mission abroad, if accepted by the Health Board or endorsed by Scottish Ministers as Reckonable Service; or

- (e) it comprises up to a maximum of four years clinical service in a country or territory outside the United Kingdom–

- (i) which followed the date of first registration of the GP provider in that country or territory, and

- (ii) in circumstances where–

- (aa) on 31st March 2003, that period of clinical service was counted by a Health Board as a period of registration for the purposes of a calculation of the annual rate of the GP Provider's Seniority Payment under the Red Book, and

- (bb) that period of clinical service is not counted as reckonable service by virtue of any of the preceding sub-paragraphs in this paragraph.

### ***Calculation of years of Reckonable Service***

13.4 Claims in respect of years of service are to be made to the Health Board, and should be accompanied by appropriate details, including dates, of relevant clinical service. Where possible, claims should be authenticated from appropriate records, which may in appropriate circumstances include superannuation records. If the Health Board is unable to obtain authentication of the service itself, the onus is on the GP provider to provide documentary evidence to support his claim (although payments may be made while verification issues are being resolved). Health Boards should only count periods of service in a calculation of a GP provider's Reckonable Service if they are satisfied that there is sufficient evidence to include that period of service in the calculation.

13.5 In determining a GP provider's length of Reckonable Service–

- (a) only clinical service is to count towards Reckonable Service;
- (b) only clinical service since the date on which the GP provider first became registered (be it temporarily, provisionally, fully or with limited registration) with the General Medical Council, or an equivalent authority in another EEA Member State, is to count towards

Reckonable Service, with the exception of Reckonable Service prior to registration that is taken into account by virtue of paragraph 13.3(e);

- (c) periods of part-time and full-time working count the same; and
- (d) generally, breaks in service are not to count towards Reckonable Service, but periods when doctors were taking leave of absence (i.e. they were absent from a post but had a right of return) due to compulsory national service, maternity leave, paternity leave, adoption leave, parental leave, holiday leave, sick leave or study leave, or because of a secondment elective or similar temporary attachment to a post requiring the provision of clinical services, are to count towards Reckonable Service.

13.6 Claims in respect of clinical service in or on behalf of armed forces pursuant to paragraph 13.3(c), are to be considered in the first instance by the Health Board, and should be accompanied by appropriate details, including dates and relevant postings. If the Health Board is not satisfied that the service should count towards the GP provider's Reckonable Service as a doctor, it is to put the matter to Scottish Ministers, together with any comments it wishes to make.

13.7 Before taking a decision on whether or not to endorse the claim, Scottish Ministers will then consult the Ministry of Defence or the equivalent authorities of the country in whose, or for whose, armed forces the GP provider served or worked. Generally, the only service that will be endorsed is service where the GP provider undertook clinical duties (whether on military service or in a civilian capacity), and Scottish Ministers have received acceptable confirmation of the nature and scope of the clinical duties performed by the GP provider from the relevant authorities.

13.8 Claims in respect of clinical service for or on behalf of diplomatic missions abroad pursuant to paragraph 13.3(d) are to be considered in the first instance by the Health Board, and should be accompanied by appropriate details, including dates and relevant postings. If the Health Board is not satisfied that the service should count towards the GP provider's Reckonable Service as a doctor, it is to put the matter to Scottish Ministers, together with any comments it wishes to make.

13.9 Before taking a decision on whether or not to endorse the claim, Scottish Ministers will consult the Foreign and Commonwealth Office. Generally, the only service that will be endorsed is service where the GP provider undertook clinical duties for—

- (a) members of the Foreign and Commonwealth Office and their families;
- (b) members of the Overseas Development Administration and their families;
- (c) members of the British Council and their families;
- (d) British residents, official visitors and aid workers;



- (e) Commonwealth and EEA Member State official visitors;
- (f) staff and their families of other Commonwealth, EEA Member State or friendly State diplomatic missions,

and Scottish Ministers have received acceptable confirmation of the nature and scope of the clinical duties performed by the GP provider from the relevant authorities.

***Determination of the relevant dates***

13.10 Once a GP provider’s years of Reckonable Service have been determined, a determination has to be made of two dates–

- (a) the date a GP provider’s Reckonable service began, which is the date on which his first period of Reckonable Service started (his “Seniority Date”); and
- (b) the GP provider’s qualifying date (see paragraph 13.2).

***Calculation of the full annual rate of Seniority Payments***

13.11 Once a GP provider has reached his qualifying date, he is entitled to a Seniority Payment in respect of his service as a GP provider thereafter. The amount of his Seniority Payment will depend on two factors: his Superannuable Income Fraction, and his number of years of Reckonable Service.

13.12 At the end of each quarter, the Health Board is to make an assessment of the Seniority Payments to be made in respect of individual GP providers working for or on behalf of its GMS contractors. If–

- (a) a GP provider’s Seniority Date is on the first date of that quarter, or falls outside that quarter, his Years of Reckonable Service are the number of complete years since his first Seniority Date, and the full annual rate of the Seniority Payment payable in respect of him is the full annual rate opposite his Years of Reckonable Service in the Table below; and
- (b) the GP provider’s Seniority Date falls in that quarter on any date other than the first date of that quarter, the full annual rate of the Seniority Payment payable in respect of him changes on his Seniority Date – and so in respect of that quarter, the full annual rate of the Seniority Payment payable in respect of him is to be calculated as follows–
  - (i) calculate the daily rate of the full annual rate of payment for the first total of Years of Reckonable Service relevant to him (i.e. divide the annual rate by 365 or 366 where the relevant year includes 29<sup>th</sup> February), and multiply that daily rate by the number of days in that quarter before his Seniority Date,

(ii) calculate the daily rate of the full annual rate of payment for the second total of Years of Reckonable Service relevant to him (i.e. divide the annual rate by 365 or 366 where the relevant year includes 29<sup>th</sup> February), and multiply that daily rate by the number of days in that quarter after and including his Seniority Date, then add the totals produced by the calculations in heads (i) and (ii) together, and multiply by four.

**TABLE**

Years of Reckonable Service	Full annual rate of payment per practitioner
0	0
1	0
2	0
3	0
4	0
5	0
6	600
7	672
8	753
9	843
10	944
11	1,057
12	1,184
13	1,326
14	1,486
15	1,664
16	3,185
17	3,504
18	3,854
19	4,239
20	4,663
21	5,129
22	6,785
23	6,989
24	7,198
25	7,414
26	7,637
27	7,866
28	8,225
29	8,455
30	8,692
31	8,935
32	9,186
33	9,443
34	9,707
35	9,979
36	10,258
37	10,546
38	10,841
39	11,144
40	11,457

41	11,777
42	12,107
43	12,446
44	12,795
45	13,153
46	13,521
47	13,900

13.13 Until 31st March 2009, if, for any GP provider, the full annual rate payable in respect of him, as calculated above, is less than the total amount due to him -

- (a) on 31st March 2003 as the full annual rate of his Seniority Payment under the Red Book; plus
- (b) on 31st March 2004 as the full annual rate of his Retention Incentive Scheme payment under the Red Book,

that GP provider is entitled to at least that total amount as the full annual rate of his Seniority Payments.

***Superannuable Income Fractions***

13.14 In all cases, the full annual rate of a Seniority Payment for a GP provider is only payable under this SFE in respect of a GP provider who has a Superannuable Income Fraction of at least two thirds.

13.15 For these purposes, a GP provider’s Superannuable Income Fraction is the fraction produced by dividing—

- (a) NHS Superannuable profits from all sources for the financial year to which the Seniority Payment relates, as reported on his certificate submitted to the Health Board in accordance with paragraph 22.10, excluding any amount in respect of Seniority Payments; by
- (b) the Average Adjusted Superannuable Income.

13.16 The Average Adjusted Superannuable Income is to be calculated as follows—

- (a) all the NHS profits, *from the previous financial year*, of the type mentioned in paragraph 13.15(a) of all the GP providers in Scotland who have submitted certificates to a Health Board in accordance with paragraph 22.10 by a date still to be fixed are to be aggregated; then
- (b) this aggregate is then to be divided by the number of GP providers in respect of which the aggregate was calculated; then
- (c) the total produced by sub-paragraph (b) is to be adjusted to take account of the shift towards less than full-time working. The index by which the amount is to be adjusted is to be the same as the index for

the financial year to which the calculation of Average Adjusted Superannuable Income relates by which the uprating factor for pensions is to be adjusted to take account of the shift towards less than full-time working,

and the total produced by sub-paragraph (c) is the Average Adjusted Superannuable Income amount for the calculation in paragraph 13.15.

13.17 If the GP provider has a Superannuable Income Fraction of one third or between one third and two thirds, only 60% of the full annual amount payable in respect a GP provider with his Reckonable Service is payable under this SFE in respect of him. If he has a Superannuable Income Fraction of less than one third, no Seniority Payment is payable under this SFE in respect of him.

### ***Amounts payable***

13.18 Once a GP provider's full annual rate in respect of a quarter has been determined, and any reduction to be made in respect of his Superannuable Income Fraction has been made, the resulting amount is to be divided by four, and that quarterly amount is the Quarterly Superannuation Payment that the Health Board must pay to the contractor under his GMS contract in respect of the GP provider.

13.19 If, however, the GP provider's—

- (a) qualifying date falls in that quarter, the quarterly amount is instead to be calculated as follows: the annual amount (taking account of any reduction in accordance with the GP provider's Superannuable Income Fraction) is to be divided by 365 (or 366 where the relevant year includes 29<sup>th</sup> February), and then multiplied by the number of days in the quarter after and including his qualifying date; and
- (b) retirement date falls in that quarter, the quarterly amount is instead to be calculated as follows: the annual amount (taking account of any reduction in accordance with the GP provider's Superannuable Income Fraction) is to be divided by 365 (or 366 where the relevant year includes 29<sup>th</sup> February), and then multiplied by the number of days in the quarter prior to the GP provider's retirement date.

13.20 Payment of the Quarterly Seniority Payment is to fall due on the last day of the quarter to which it relates (but see paragraph 21.7).

### ***Conditions attached to payment of Quarterly Seniority Payments***

13.21 A Quarterly Seniority Payment, or any part thereof, is only payable to a contractor if the following conditions are satisfied—

- (a) if a GP provider receives a Quarterly Seniority Payment from more than one contractor, those payments taken together must not amount to more than one quarter of the full annual rate of Seniority Payment in respect of him;

- (b) the contractor must make available to the Health Board any information which the contractor does not have but needs, and the contractor either has or could reasonably be expected to obtain, in order to calculate the payment;
- (c) all information provided pursuant to or in accordance with subparagraph (b) must be accurate; and
- (d) a contractor who receives a Seniority Payment in respect of a GP provider must give that payment to that doctor–
  - (i) within one calendar month of it receiving that payment, and
  - (ii) as an element of the personal income of that GP provider subject (in the case of a GP provider who is a shareholder in a contractor that is a company limited by shares) to any lawful deduction of income tax and national insurance.

13.22 If the conditions set out in paragraph 13.21(a) to (c) are breached, the Health Board may in appropriate circumstances withhold payment of any or any part of a payment to which the conditions relate that is otherwise payable.

13.23 If a contractor breaches the condition in paragraph 13.21(d), the Health Board may require repayment of any payment to which the condition relates, or may withhold payment of any other payment payable to the contractor under this SFE, to the value of the payment to which the condition relates.

## 14. Golden Hello Scheme

14.1 Under the Golden Hello Scheme, a lump sum “golden hello” payment is made to doctors who are starting out as GP performers in their first eligible post. All eligible doctors receive a standard payment and those starting work in specified Health Board areas also receive an additional payment.

### *Standard payments under the Golden Hello Scheme*

14.2 A doctor will be eligible for a standard payment under the Golden Hello Scheme if, after 1st April 2005, he takes up a post as a GP performer and—

- (a) the post is as a GP performer employed or engaged by a contractor;
- (b) the post, if part-time—
  - (i) involves a working commitment that generates a Time Commitment Fraction of at least one fifth; or
  - (ii) with any other post held by the doctor that also entails performing primary medical services together involve working commitment that generates a Time Commitment Fraction of at least one fifth;
- (c) if the doctor is an employee of the contractor, he is on a contract—
  - (i) for an indefinite period (but not a fixed number of sessions), or
  - (ii) for a fixed term of more than two years,
- (d) subject to paragraph 14.3, prior to starting work in that post, he has not—
  - (i) been included in the performers list or medical list of any Health Board, except as a GP Registrar (unless this was because of temporary arrangements made by a Health Board for the provision of general medical services or the performance of primary medical services following the suspension of a doctor),
  - (ii) been employed or engaged (except as a locum) by a GP principal to assist, as a medical practitioner, in the provision of general medical services, or worked (except as a locum) as a GP performer—
    - (aa) either full-time, or part-time with a working commitment generating a Time Commitment Fraction

of at least one quarter, if he took up post before 29th November 2002, or at least one fifth if he took up post on or after 29th November 2002, and

- (bb) under a contract for an indefinite period (but not for a fixed number of sessions) or for a fixed term of more than two years, or
- (iii) been engaged (except as a locum) as a pilot scheme provider or an employee of a pilot scheme provider, or worked (except as a locum) as a medical practitioner performing primary medical services under a section 17C (formerly Personal Medical Services) contract–
  - (aa) either full-time, or part-time with a working commitment generating a Time Commitment Fraction of at least one quarter, if he took up the post before 29th November 2002 or at least one fifth, if he took up the post on or after 29th November 2002, and
  - (bb) under a contract for an indefinite period (but not for a fixed number of sessions) or for a fixed term of more than two years,

unless he only comes within heads (i) to (iii) because of his participation in the GP Retainer Scheme and the claim pursuant to this Section relates to his first post after leaving the GP retainer scheme; and

- (e) subject to the provisions in this Section for making further payments because of new commitments, he has not previously received a standard payment under–
  - (i) this Section,
  - (ii) paragraph 15 of the Red Book, or
  - (iii) the Golden Hello Scheme under a section 17C (formerly Personal Medical Services) contract.

14.3 Paragraph 14.2(d) shall not apply to a GP performer who did not perform general medical services or personal medical services between 24th June 2002 and 24th September 2002 (except as a locum).

#### ***Additional payments under the Golden Hello Scheme***

14.4 In addition to the standard payment, practitioners taking up an eligible post in a practice within an area attracting additional payments on the first date in post will be eligible to receive a further payment. Criteria for payment shall be the same as for

standard payments to doctors taking up an eligible post as set out in paragraph 14.2. The criteria may be reviewed by Scottish Ministers from time to time. Additional payments are available as follows:

14.4.1 A supplementary golden hello of £5,000 will be paid to every GP taking up an eligible post in a remote and rural area. For these purposes, remote and rural is defined as practices with an out of hours rota of 1:3 or worse, or island practices as listed at Annex H. For out of hours cases, this payment will be available only where the Health Board, in consultation with the GP Sub-Committee, confirms that the reason for the heavy out of hours commitment is the practice's location.

14.4.2 A supplementary golden hello averaging £5,000 will be payable to every eligible GP taking up a substantive post in one of the 40% most deprived practices in Scotland. These practices have been defined using information held centrally which shows the level of deprivation payments paid to each practice per 1,000 patients during 2003/04. Payments will be made on a sliding scale with increases at a linear rate between £2,500 and £7,500 with those practices in the most deprived areas receiving the highest payment. Health Boards will hold a list of such practices and will ensure that any new GP applying for a post knows in advance whether the post attracts a supplementary payment of this nature and if it does, the level of such payment.

14.4.3 Where a practice meets both the remote and rural and the deprivation criteria, the GP will be eligible for one supplementary golden hello only, whichever is the more favourable.

### ***Job Sharers***

14.5 Each partner in a job-sharing arrangement will be eligible individually for payment under paragraphs 14.2 and 14.4 if he or she satisfies the appropriate conditions.

14.6 The amount of money payable will be dependant on the time commitment of the job-sharer.

### ***Changes in circumstances***

#### Extra payments

14.7 These paragraphs are intended to ensure that if a practitioner has a change in circumstances involving an increase in time commitment and/or a move to or increase in time commitment in an area that attracts additional payments within two years of the first appointment she or he will be entitled to make a second claim based on these new circumstances. An increase in commitment and/or move to an area that attracts additional payments under paragraphs 14.8-14.12 may occur within post, by starting a different post or by taking a second post.

14.8 An eligible practitioner who increases his or her commitment (in an eligible position as specified in 14.2) within 6 months of taking up an eligible post, to such a level as would have attracted a higher payment had the position been the first held



will receive the standard payment for their new commitment less any payment they have previously been awarded under this paragraph.

14.9 An eligible practitioner who between six months and two years of joining general practice increases his or her commitment (in an eligible position as specified in 14.2) to such a level as would have attracted a higher payment had the position been the first held, will receive half of the difference between the full payment for their current commitment and the payment for their previous commitment as awarded under this paragraph.

14.10 Practitioners whose changes in circumstances involve a move to an area attracting additional payments, at the time of that change, will be eligible for extra additional payments. These payments will be calculated as in paragraphs 14.8-14.10. An increase in commitment will not be necessary to attract payments under this paragraph.

14.11 Where payment under 14.10 is due to a practitioner taking a second post, payments should be based only on the practitioner's percentage commitment in the area attracting additional payments.

14.12 Practitioners who move to another post within the same area which attracted additional payments when she/he took up the first post but has subsequently ceased to attract additional payments and increases his/her commitment (in a eligible post as specified in 14.2) to such a level as would have attracted a higher payment had the position been the first held, will be eligible for extra additional payments. These will be calculated as in paragraphs 14.8-14.9.

14.13 A doctor in receipt of a standard payment does not receive an additional payment where:

- the area in which they practice is subsequently designated as attracting an additional payment
- she/he moves to a post within the same area which was not included in the list of those areas attracting an additional payment at the time she/he took up the first post but has subsequently been designated as an area attracting additional payments.

#### Return of Payments

14.14 Where, within two years, a practitioner in receipt of payments under paragraph 14.2 or 14.4 and 14.7 – 14.13 stops providing or assisting in the provision of general medical services or performing section 17C (formerly Personal Medical Services) arrangements as:

- a GP principal on the medical list of a Health Board
- an employee of a principal assisting in the provision of general medical services.
- A section 17C (formerly Personal Medical Services) performer

she or he will be required to return some or all of the payment received as specified in paragraph 14.15.

14.15 The proportion of the payment returnable will be dependent on the amount of time spent in general practice as shown below:

- i. less than 6 months 100%
- ii. from 6 months to 2 years 50%

14.16 The provisions for the return of payments will not apply where the Health Board is satisfied that the practitioner has ceased to work in this capacity due to:

- i. death
- ii. enforced early retirement from general practice due to illness or injury
- iii. exceptional personal circumstances and with the approval of the Health Board
- iv. maternity (or other extended parenting leave agreed by the Health Board) provided the GP gives an undertaking that (s)he will return to practise and does so within a reasonable period, to be considered case-by-case by the Health Board. (As a minimum absences of up to two years will normally be considered reasonable, but requests for any longer periods should be considered sympathetically by the Health Board).
- v. transfer to a post under GMS or section 17C (formerly Personal Medical Services) arrangements elsewhere in the UK

14.17 Periods of absence under 14.16 iii and iv shall not be included in the computation of periods of time for the purposes of paragraphs 14.7 – 14.15 and 14.18.

14.18 Practitioners in receipt of an additional payment shall be liable to return some or all of the sum received if they move to an area, which at the time of the move does not attract an additional payment, within 2 years of receiving it. The criteria for return of the money will be the same as set out in paragraphs 14.14 – 14.16 and 14.19.

14.19 Practitioners in receipt of an additional payment shall be liable to return the sum received if:

- the area in which she/he practices ceases to attract additional payments
- she/he moves to another post within the same area which attracted additional payments when she/he took up the first post but has subsequently ceases to attract additional payments.

### ***Relocation costs***

14.20 Where a GP (whether newly qualified or not) takes up a substantive post in a remote and rural area (as defined at Paragraph 14.4.1), support for relocation costs is available as follows:

- Subject to the submission of three competitive tenders where practicable,
- GPs are eligible to claim up to the first £2,000 of relocation costs, assessed against the lowest tender.

### ***Recruitment costs***

14.21 Subject to submission of appropriate receipts, practices in remote and rural areas as defined at paragraph 14.4.1 above, are eligible to claim up to the first £2,000 of recruitment costs, including, in exceptional circumstances, the cost of locum cover where there were difficulties and delays in finding a replacement partner.

14.22 Applications for payment should be made to Health Boards within 12 months of the date on which the doctor took up the eligible post or from the date on which the new time commitment started.

### ***Rates of payment***

14.23 Rates of payment will be at the following rates.

Standard Payment	
Full-time or Part-time with a time commitment fraction of at least 1/2	£5,000
Part-time with a time commitment fraction of less than 1/2	£3,000
Additional Payment	
Remote and Rural Area	£5,000*
40% most deprived practices	Between £2,500-£7,500*
*To be reduced pro-rata depending on time commitment	

## **15. Payment of Fees to Doctors Under Section 47 of Part 5 of the Adults with Incapacity (Scotland) Act 2000.**

15.1 Where a general practitioner carries out an assessment and issues a certificate to allow the general practitioner or member of the Primary Health Care Team who has had authority appropriately delegated and who is acting on his behalf or under his instructions to treat the patient, no fee is payable.

### ***Where an independent health professional seeks confirmation that a certificate of incapacity is in force***

15.2 Where a medical certificate of incapacity already exists for a patient to permit general practitioners and staff acting on their behalf to treat a patient, an 'independent health professional' (eg dentists, opticians and community pharmacists) may be permitted to draw upon this existing medical certificate, providing it covers the intervention proposed to treat the patient in question. Under this arrangement practices are not entitled to charge a fee.

### ***Where a general practitioner is requested by an independent health professional to carry out an assessment***

15.3 Where a general practitioner has not issued a certificate of incapacity and one is believed to be required by another independent health professional to treat the patient under the NHS, the practice may receive a fee for the assessment and completion of the certificate for the purposes of the independent health professional. The fee payable is £105.56.

15.4 Where a GP is required to undertake a second assessment and produce an additional certificate for an independent health professional to provide treatment under the NHS, having already issued a certificate which enabled the GP to treat a patient, payment of a fee of £105.56 is payable to the GP.

15.5 Applications for payment should be completed and sent to the local Practitioner Services Division for processing and payment.

15.6 Claims will be the subject of checks by Practitioner Services Division with the independent health professional requesting the assessment and certificate.

## **16. NOT ALLOCATED**

### **17. Doctors' Retainer Scheme**

17.1 This is an established Scheme designed to keep doctors who are not working in general practice in touch with general practice.

#### ***Payments in respect of sessions undertaken by members of the Scheme***

17.2 Subject to paragraph 17.2A, where—

- (a) a contractor who is considered as a suitable employer of members of the Doctors' Retainer Scheme by the Director of Postgraduate GP Education employs or engages a member of the Doctors' Retainer Scheme; and
- (b) the service sessions for which the member of the Doctors' Retainer Scheme is employed or engaged by that contractor have been arranged by the local Director of Postgraduate GP Education,

the Health Board must pay to that contractor under its GMS contract £59.18 in respect of each full session that the member of the Doctors' Retainer Scheme undertakes for the contractor in any week, up to a maximum of four sessions per week.

#### ***Provisions in respect of leave arrangements***

17.2A The Health Board must pay to the contractor under its GMS contract any payment payable under paragraph 17.2 in respect of any session which the member of the Doctors' Retainer Scheme is employed or engaged to undertake but which that member does not undertake because they are absent due to leave related to—

- (a) annual holiday up to a maximum number of sessions annually equivalent to 6 weeks' worth of arranged sessions for the member of the Doctors' Retainer Scheme;
- (b) maternity, paternity or adoption, in accordance with the circumstances and for the periods referred to in Section 9 (payments for locums covering maternity, paternity and adoption leave);
- (c) parental leave, in accordance with statutory entitlements (except that the normal statutory qualifying period of one year's service with the contractor does not apply);
- (d) sickness, for a reasonable period as agreed by the contractor and the Health Board:

- (e) an emergency involving a dependent, in accordance with employment law and any guidance issued by the The Department for Business,Enterprise and Regulatory Reform
- (f) other pressing personal or family reasons where the contractor and the Health Board agree that the absence of the member of the Doctors' Retainer Scheme is necessary and unavoidable.

***Payment conditions***

17.3 Payments under this section are to fall due at the end of the month in which the session to which the payment relates takes place. However, the payments, or any part thereof, are only payable if the contractor satisfies the following conditions–

- (a) the contractor must inform the Health Board of any change to the member of the Doctors' Retainer Scheme's working arrangements that may affect the contractor's entitlement to a payment under this section;
- (b) the contractor must inform the Health Board of any absence on leave of the member of the Doctors' Retainer Scheme and the reason for such absence;
- (c) in the case of any absence on leave in respect of which there are any matters to be agreed between the contractor and the Health Board in accordance with paragraph 17.2A above, the contractor must make available to the Health Board any information which the Health Board does not have but needs, and which the contractor either has or could be reasonably expected to obtain, in order to form an opinion in respect of any of the matters which are to be agreed between the contractor and the Health Board;
- (d) the contractor must inform the Health Board if the doctor in respect of whom the payment is made ceases to be a member of the Doctors' Retainer Scheme, or if it ceases to be considered a suitable employer of members of the Doctors' Retainer Scheme by the Director of Postgraduate GP Education.

17.4 If a contractor breaches any of these conditions, the Health Board may, in appropriate circumstances, withhold payment of any payment otherwise payable under this Section.

## 18. Dispensing

18.1 Payment is made for the supply of drugs and appliances only where they have been supplied by a dispensing practice in accordance with arrangements made under Schedule 5, Part 3 of the National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004. In this and the following paragraphs "appliances" means appliances listed in the Drug Tariff (ie the Statement prepared by Scottish Ministers under regulation 9 of the National Health Service (Pharmaceutical Services)(Scotland) Regulations 1995.

18.2 Some practices are prescribing practices as well as dispensing practices, ie their lists include some patients who can conveniently obtain their medicines etc from chemists, and for whom, accordingly, the practice is not required to dispense medicines but to write prescriptions and hand them to the patient in the ordinary way. This section does not apply to the supply of drugs and appliances to these 'prescribing patients' but only to those 'dispensing patients' for whom the practice has been required by the Health Board to dispense.

18.3 Payments to a dispensing practices for drugs, appliances, etc supplied to patients on the practice dispensing list, temporary residents and patients who are receiving maternity medical services or contraceptive services from the practice (and in respect of whom the Health Board have required the practice to dispense) shall be as follows:

- i. the basic price. For proprietary preparations this is the List Price as defined in the Drug Tariff. For non-proprietary items the basic price is the Tariff price as listed in Parts 7 and 9 of the Drug Tariff or, when not so listed, the price as determined in accordance with paragraph 11 of Part 1 of the Tariff . The price of appliances shall be that listed in the Drug Tariff.

**less**, except where the practice has been exempted under paragraph 18.7, 18.8 or 18.9 below, a discount calculated in accordance with schedule 1 to this paragraph;

- ii. an on-cost allowance of 10.5% of the basic price **before** deduction of any discount under schedule 1;
- iii. a container allowance of 3.8 pence per prescription;
- iv. a dispensing fee as shown in schedule 2 to this paragraph, other than in relation to appliances and oxygen therapy equipment;
- v. an allowance in respect of VAT in accordance with paragraph 18.5; and
- vi. if appropriate, exceptional expenses in accordance with paragraph 18.6.

A practice may not claim payment under this paragraph for a vaccine specified in Schedule 4 (a).

18.4 Payments in respect of the supply of oxygen therapy equipment shall be made in accordance with the provisions of part 10, paragraph 6 of the Drug Tariff and shall not be subject to these discount arrangements.

**18.5a For the dispensing period 1 April- 30 June 2011 only** Unless a dispensing practice is registered with Customs and Excise for Value Added Tax (VAT) purposes (normally when a registered pharmacist is employed for dispensing), a VAT allowance shall be paid to cover the VAT payable on the practice purchases of drugs and appliances and containers. The allowance shall be calculated as a percentage both of the basic price less any discount applicable under schedule 1 and of the container allowance equivalent to the rate of VAT in force on the first day of the quarter in which the items are dispensed.

18.5 b A one off VAT registration support payment of **£3000** will be paid to all dispensing practices, who were both dispensing practices and not registered for VAT at 1 April 2011, and who are not subject to the discretionary arrangements detailed in subparagraph 18.6 with their April 2011 dispensing payment.

**18.5 c For the dispensing period 1 July 2011 onwards** A VAT allowance shall be paid to cover any VAT payable on the purchase of any products listed below for personal administration under a GMS contract:

- vaccines, anaesthetics and injections;
- the following diagnostic reagents: Dick Test; Schick test; Protein Sensitisation Solutions; and Tuberculin Tests (i.e. Koch Test, Mantoux Test, Patch Test and Diagnostic Jelly);
- intrauterine contraceptive devices (including drug- releasing IUCDs, contraceptive caps and diaphragms);
- pessaries which are appliances; and
- sutures (including skin closure sutures).

No allowance will however be paid for any item which is centrally supplied as part of a programme such as the Childhood Immunisation Programme or any programme against a Pandemic Influenza Virus.

18.5 d Where after making any enquiries as it deems necessary and after consulting the GP subcommittee of the Area Medical Committee, the Board anticipates that the requirement on a practice to dispense will be time limited, for example an application has been made before 30 June 2011 to open a pharmacy to serve the patients currently served by the dispensing practice concerned, the Board may agree to temporarily continue to make payments in accordance with sub paragraph 18.5a above until the practice ceases dispensing.

18.6 Where additional expenses have been incurred in obtaining from a manufacturer or wholesaler supplies of a drug or appliance (other than those items for which prices are given in Parts 2-5, 7 and 9 of the Tariff), which a practice does not frequently require to provide, payment of the amount incurred will be authorised if the practice submits a claim giving full details to the Health Board with the appropriate



prescription form and if, in any doubtful cases, the Health Board, after consultation with the GP Subcommittee of the Area Medical Committee, is satisfied that the additional expenses were necessarily incurred and were reasonable.

18.7 Where a practice is able to provide evidence and the Health Board, after making such enquiries as it deems necessary and after consulting the GP Subcommittee of the Area Medical Committee, is satisfied that by reason of the remoteness of the practice the practice is unable to obtain any discount on the basic price (see paragraph 18.3) for the purchase of drugs and appliances the Health Board shall approve the exemption of the practice from the application of the discount scale. In such cases the Health Board shall inform Practitioner Services Division of the period during which the exemption should be applied. Payments will then be calculated on the full, and not the discounted, basic price. Such an exemption may be granted for a period of up to one year and may be renewed for further such periods if the practice is able to satisfy the Health Board that he or she continues to be unable to obtain any discount.

18.8 Where

- a. a practice is able to provide evidence and
- b. the Health Board after making such enquiries as it deems necessary and after consulting the GP Subcommittee of the Area Medical Committee is satisfied

that by reason of

- i. the remoteness of the practice or
- ii the small quantities of drugs and appliances the practice needs to buy (normally where the total monthly basic price to be reimbursed is below that which would attract an adjustment for discount )

the practice is only able to obtain drugs and appliances at a price in excess of the basic price (see paragraph 18.3) and on average more than 5% above the basic price then Practitioner Services Division shall approve a special payment. Practitioner Services Division shall determine the appropriate level of the special payment from the scale below:

Where on average the price paid (excluding VAT) is	Special Payment
in excess of 5% and up to 10% over basic price	5% over basic price
in excess of 10% and up to 15% over basic price	10% over basic price
in excess of 15% and up to 20% over basic price	15% over basic price
in excess of 20% over basic price	20% over basic price

Practitioner Services Division shall apply the rate for the special payment and the period during which it should be applied to the basic price payable. The VAT allowance (see paragraph 18.5) shall be calculated on the basic price plus the special payment. The oncost allowance shall be calculated on the basic price. No discount shall be applied. Such payments may be granted for a period of up to one year and may be renewed for further such periods at the same or a different rate if the practice is able to satisfy the Health Board that it continues to meet the above conditions.

### ***Transitional Arrangements***

18.9 Where a practitioner succeeds to the practice of a dispensing practitioner who at the time of his or her withdrawal from the performer list or medical list was exempted from application of the discount scale under paragraph 18.7 or was in receipt of the special payment provided under paragraph 18.8 and the successor has made application to Practitioner Services Division for such exemption or special payment, Practitioner Services Division shall treat the practitioner as qualifying for the exemption or special payment as appropriate for a period of 3 months from the date of his or her admission to the performers list or until his or her application is determined, whichever is the earlier.

### ***Claims***

18.10 Payments are based on the monthly surrender and pricing of the prescriptions issued. Prescriptions for proprietary preparations (including prescriptions for non-proprietary preparations available only in proprietary form) should be endorsed with the size of the pack used in dispensing. All the prescriptions should then be noted, counted and sent under cover of Form GP34A to the appropriate Prescription Pricing Bureau (see schedule 3) within the first week of the month following that in which the prescriptions were dispensed.

18.11 Dispensing practices must submit all prescriptions for pricing in one batch under cover of one claim form relating to the practice in order that the appropriate rate of discount under schedule 1 may be applied. Practices may if they wish sub-divide the partnership batch into bundles relating to the individual practitioners and attach separate claims to each for the purpose of calculating the dispensing fees provided that all such bundles are sent to Practitioner Services Division together in one batch for the partnership.

### ***Payments On Account***

18.12 Monthly payments on account will be made by Practitioner Services Division based on about 80% of the sum due. The estimated sum due will be based on the number of prescriptions submitted for pricing and the average payments per prescription for the previous authorisation. In the case of a practice who has not previously dispensed in a practice and for whom no such authorisation is available, the estimated sum due will normally be based on the last authorisation for the practice, as appropriate. For prescriptions dispensed in February and submitted in March the practice should receive at the beginning of April about 80% of the estimated sum due for February plus the balance of the sum due for prescriptions dispensed in January. Where, because the average cost of prescriptions varies significantly from month to month, it appears to Practitioner Services Division that

payment of the amount notified would be likely to result in an overpayment, Practitioner Services Division will pay a lesser amount on account.

### ***Examination Of Prescription Forms***

18.13 Priced prescription forms will not normally be returned to a practice. However any practice which has supplied drugs and appliances and which wishes to examine their prescription forms after they have been priced should inform Practitioner Services Division so that they may make the necessary arrangements. It would normally be from 2 to 6 months after pricing before the forms are available for inspection at Practitioner Services Division premises.

### ***Accounting***

18.14 In order to ensure that the annual surveys of practitioners' practice expenses carried out by the Inland Revenue are as accurate as possible, practitioners should ensure that their actual expenditure on drugs and appliances are shown 'gross' in their accounts. Payments under this paragraph should be brought to account 'gross' as 'income'.

### ***Payments for the provision of flu vaccines***

18.15 The provisions set out in paragraphs 18.1 to 18.5 do not cover remuneration and reimbursement arrangements for dispensing and non dispensing practices in respect of the provision of influenza vaccine. Specific arrangements in relation to the reimbursement costs and fees for provision of vaccines for the 2011-12 influenza season are detailed in NHS Circular PCA(M/P)(2011)1 issued on 5 January 2011.

## PARAGRAPH 18/SCHEDULE 1: DISCOUNT SCALE

Total Basic Price of all Prescriptions submitted for Pricing by Practitioner/ Practice in Month £	Rate of Discount to be applied to Basic Practice %	Total Basic Price of all Prescriptions submitted for Pricing by Practitioner/ Practice in Month £	Rate of Discount to be applied to Basic Practice %
1 - 1000	0.00	6501 - 6625	5.20
1001 - 1125	0.08	6626 - 6750	5.29
1126 - 1250	0.15	6751 - 6875	5.37
1251 - 1375	0.21	6876 - 7000	5.45
1376 - 1500	0.26	7001 - 7125	5.54
1501 - 1625	0.32	7126 - 7250	5.61
1626 - 1750	0.37	7251 - 7375	5.69
1751 - 1875	0.42	7376 - 7500	5.76
1876 - 2000	0.48	7501 - 7625	5.83
2001 - 2125	0.54	7626 - 7750	5.90
2126 - 2250	0.61	7751 - 7875	5.96
2251 - 2375	0.68	7876 - 8000	6.03
2376 - 2500	0.77	8001 - 8125	6.09
2501 - 2625	0.88	8126 - 8250	6.15
2626 - 2750	0.99	8251 - 8375	6.21
2751 - 2875	1.12	8376 - 8500	6.27

2876 - 3000	1.25	8501 - 8625	6.32
3001 - 3125	1.42	8626 - 8750	6.38
3126 - 3250	1.59	8751 - 8875	6.43
3251 - 3375	1.76	8876 - 9000	6.48
3376 - 3500	1.93	9001 - 9125	6.53
3501 - 3625	2.09	9126 - 9250	6.58
3626 - 3750	2.24	9251 - 9375	6.62
3751 - 3875	2.38	9376 - 9500	6.67
3876 - 4000	2.53	9501 - 9625	6.72
4001 - 4125	2.69	9626 - 9750	6.76
4126 - 4250	2.85	9751 - 9875	6.80
4251 - 4375	3.01	9876 - 10000	6.84
4376 - 4500	3.15	10001 - 10125	6.88
4501 - 4625	3.29	10126 - 10250	6.92
4626 - 4750	3.42	10251 - 10375	6.96
4751 - 4875	3.54	10376 - 10500	7.00
4876 - 5000	3.68	10501 - 10625	7.04
5001 - 5125	3.81	10626 - 10750	7.07
5126 - 5250	3.86	10751 - 10875	7.11
5251 - 5375	4.09	10876 - 11000	7.14

5376 - 5500	4.23	11001 - 11125	7.18
5501 - 5625	4.35	11126 - 11250	7.21
5626 - 5750	4.47	11251 - 11375	7.24
5751 - 5875	4.59	11376 - 11500	7.27
5876 - 6000	4.70	11501 - 11625	7.31
6001 - 6125	4.81	11626 - 11750	7.34
6126 - 6250	4.91	11751 - 11875	7.37
6251 - 6375	5.01	11876 - 12000	7.39
6376 - 6500	5.11	12000+ -	7.42

NB: Where a practitioner is in partnership the rate of discount to be applied is that which relates to the total Basic Price of all prescriptions submitted for pricing by all the partners.

## PARAGRAPH 18/SCHEDULE 2: FEE SCALE

Dispensing Fees (see paragraph 18.3) - marginal fee scale for application to prescriptions submitted for pricing by practitioner/practice per month.

Prescriptions in Bands	Payment per* Prescription from 1.4.2002
1-100	154.7
101-200	153.7
201-300	150.2
301-450	147.2
451-600	142.7
601-650	122.2
651-700	119.2
701-750	115.2
751-800	113.7
801-850	108.2
851-900	103.2
901-950	100.2
951-1000	94.7
1001-1050	92.7
1051-1100	88.2

1101-1150	83.7
1151-1200	81.7
1201-1250	76.7
1251-1300	74.7
1301-1350	70.2
1351-1400	64.2
1401-1450	62.2
1451-1500	57.2
1501-1750	84.7
1751-2000	94.7
2001-2250	92.7
2251-2500	90.2
2501-2750	88.7
2751-3000	86.2
3001-3250	85.7
3251-3500	84.7
3501-3750	83.2
3751-4000	82.7
4001-4250	81.7
4251-4500	79.7



4501-4750	78.7
4751-5000	77.7
5001-5250	77.2
5251-5500	75.7
5501-5750	74.7
5751-6000	73.7
6001-6250	72.7
6251-6500	71.7
6501-6750	70.7

\* Payment will be reduced by 1p per prescription for each additional 250 prescriptions per month in excess of 6,750.

## **PARAGRAPH 18/SCHEDULE 3: ADDRESS FOR CLAIMS**

ADDRESSES TO WHICH DISPENSING PRACTICES SHOULD SUBMIT THEIR CLAIMS

Practitioner Services Division (Pharmacy)

3 Bain Square

Livingston

EH54 7DQ

## **PARAGRAPH 18/ SCHEDULE 4: LIST OF VACCINES**

Subject to the provisions of (b) below, no payments are payable under Section 18 in respect of the products listed in paragraph (a) below, which are centrally supplied as part of the Childhood Immunisation Programme-

(a) MMR (Measles, Mumps and Rubella); BCG (Bacillus Calmette-Guerin); Tuberculin Purified Protein Derivative; Meningococcal C conjugate vaccine (for children under 5 and persons entering the first year of higher education);

DTaP/IPV/HiB (Diphtheria/Tetanus/Pertussis/Inactivated Polio/ Haemophilus influenzae type B); dTaP/IPV (low dose Diphtheria/Tetanus/Pertussis/Inactivated Polio); DTaP/IPV (Diphtheria/Tetanus/Pertussis/Inactivated Polio); and Td/IPV (Diphtheria /Tetanus/ Inactivated Polio); Hib/MenC (Haemophilus influenzae type B/meningitis C) and PCV(pneumococcal);

(b) payments are payable under this Section in respect of Td/IPV (Diphtheria /Tetanus/ Inactivated Polio) where that product is used for the treatment of adults or supplied to patients who require such products prior to travelling outside the United Kingdom and in either case where the Td/IPV product has been purchased by the contractor directly from the manufacturer.

## **PART 5**

### **PREMISES AND IT EXPENSES**

#### **19. Premises**

There are other premises costs payable under GMS contracts which are dealt with in the Primary Medical Services (Premises Development Grants, Improvement Grants and Premises Costs) Directions 2004. These include payments in respect of new premises development and improvement projects, and payments in respect of recurring premises costs such as mortgage repayments, rent payments and notional rent payments.

#### **20. IT Expenses**

20.1 NHS Boards, rather than contractors, are responsible for the purchase, maintenance, future upgrades and running costs of integrated IM &T systems for providers of services under GMS contracts, as well as for telecommunications links within the NHS and it is for them to determine the way in which this responsibility is exercised in accordance with any extant national guidance, further advice on which is provided in 'Delivering Investment in General Practice- Implementing the New GMS Contract in Scotland'.

## PART 6

### SUPPLEMENTARY PROVISIONS

#### 21. Administrative Provisions

##### *Overpayments and withheld amounts*

21.1 Without prejudice to the specific provisions elsewhere in this SFE or in the 2004/5 SFE relating to overpayments of particular payments, and without prejudice to paragraph 21.1 of the 2004/5 SFE, if a Health Board makes a payment to a contractor under its GMS contract pursuant to this SFE or the 2004/5 SFE and—

- (a) the contractor was not entitled to receive all or part thereof, whether because it did not meet the entitlement conditions for the payment or because the payment was calculated incorrectly (including where a payment on account overestimates the amount that is to fall due);
- (b) the Health Board was entitled to withhold all or part of the payment because of a breach of a condition attached to the payment, but is unable to do so because the money has already been paid; or
- (c) the Health Board is entitled to repayment of all or part of the money paid,

the Health Board may recover the money paid by deducting an equivalent amount from any other payment payable pursuant to this SFE, and where no such deduction can be made, it is a condition of the payments made pursuant to this SFE that the contractor must pay to the Health Board that equivalent amount.

21.2 Where a Health Board is entitled pursuant to this SFE to withhold all or part of a payment because of a breach of a payment condition, and the Health Board does so or recovers the money by deducting an equivalent amount from another payment in accordance with paragraph 21.1, it may, where it sees fit to do so, reimburse the contractor the amount withheld or recovered, if the breach is cured.

##### *Underpayments and late payments*

21.3 Without prejudice to the specific provisions elsewhere in this SFE relating to underpayments of particular payments, if the full amount of a payment that is payable pursuant to this SFE has not been paid before the date on which the payment falls due, then unless—

- (a) this is with the consent of the contractor; or
- (b) the amount of, or entitlement to, the payment, or any part thereof, is in dispute,

once it falls due, it must be paid promptly (see regulation 22 of the 2004 Regulations).

21.4 If the contractor's entitlement to the payment is not in dispute but the amount of the payment is in dispute, then once the payment falls due, pending the resolution of the dispute, the Health Board must—

- (a) pay to the contractor, promptly, an amount representing the amount that the Health Board accepts that the contractor is at least entitled to; and
- (b) thereafter pay any shortfall promptly, once the dispute is finally resolved.

21.5 However, if a contractor has—

- (a) not claimed a payment to which it would be entitled pursuant to this SFE if it claimed the payment; or
- (b) claimed a payment to which it is entitled pursuant to this SFE but a Health Board is unable to calculate the payment until after the payment is due to fall due because it does not have the information or computer software it needs in order to calculate that payment (all reasonable efforts to obtain the information, or make the calculation, having been undertaken),

that payment is (instead) to fall due at the end of the month during which the Health Board obtains the information or computer software it needs in order to calculate the payment.

### ***Payments on account***

21.6 Where the Health Board and the contractor agree (but the Health Board's agreement may be withdrawn where it is reasonable to do so and if it has given the contractor reasonable notice thereof), the Health Board must pay to a contractor on account any amount that is—

- (a) the amount of, or a reasonable approximation of the amount of, a payment that is due to fall due pursuant to this SFE; or
- (b) an agreed percentage of the amount of, or a reasonable approximation of the amount of, a payment that is due to fall due pursuant to this SFE,

and if that payment results in an overpayment in respect of the payment, paragraph 21.1 applies.

21.7 Health Boards will not be able to calculate the correct amount of GP providers' Seniority Payments during the financial year to which they relate because it

will not be possible to calculate the correct value of the GP provider's Superannuable Income Fraction until—

- (a) the Average Adjusted Superannuable Income for that financial year has been established; and
- (b) the GP provider's pensionable earnings from all sources for that financial year, excluding—
  - (i) pensionable earnings which do not appear on his certificate submitted to the Health Board in accordance with paragraph 22.10, and
  - (ii) any amount in respect of Seniority Payments, have been established.

If a Health Board cannot reach agreement with a contractor on a payment on account in respect of a Quarterly Seniority Payment pursuant to paragraph 21.6, it must nevertheless pay to the contractor on account a reasonable approximation of the Quarterly Seniority Payment, on or before the unrevised due date for payment of that payment (i.e. before it is revised in accordance with paragraph 21.5). If that payment results in an overpayment in respect of the Quarterly Seniority Payment, paragraph 21.1 applies.

#### **Payments to or in respect of suspended doctors whose suspension ceases**

21.8 If the suspension of a GP from a medical practitioners list ceases, and—

- (a) that GP enters into a GMS contract that takes effect for payment purposes on 1st April 2004, any payments that the GP received under a determination made under regulation 15(1) of the Performers List Regulations may be set off, equitably, against the payments that he is entitled to receive under his GMS contract pursuant to this SFE; or
- (b) a contractor is entitled to any payments in respect of that GP pursuant to this SFE or the 2004/5 SFE and a payment was made to the GP pursuant to a determination made under regulation 15(1) of the Performers List Regulations but the GP was not entitled to receive all or any part thereof, the amount to which the GP was not entitled may be set off, equitably, against any payment in respect of him pursuant to this SFE.

#### ***Effect on periodic payments of termination of a GMS contract***

21.9 If a GMS contract under which a periodic payment is payable pursuant to this SFE is terminated before the date on which the payment falls due, a proportion of that payment is to fall due on the last day on which the contractor is under an obligation under its GMS contract to provide essential services. The amount of the periodic

payment payable is to be adjusted by the fraction produced by dividing–

- (a) the number of days during the period in respect of which the payment is payable for which the contractor was under an obligation under its GMS contract to provide essential services; by
- (b) the total number of days in that period.

This is without prejudice to any arrangements for the recovery of money paid under the GMS contract that is recoverable as a result of the contract terminating or any breach thereof.

### ***Time limitation for claiming payments***

21.10 Payments under this SFE are only payable if claimed within 6 years of the date on which they could first have fallen due (albeit that the due date has changed pursuant to paragraph 21.5).

### ***Dispute resolution procedures***

21.11 Any dispute arising out of or in connection with this SFE between a Health Board and a contractor (except one to which paragraph 19.4(a) applies) is to be resolved as a dispute arising out of or in connection with the contractor's GMS contract, i.e. in accordance with the NHS dispute resolution procedures or by the courts (see Part 7 of Schedule 5 to the 2004 Regulations).

21.12 The procedures require the contractor and the Health Board to make every reasonable effort to communicate and cooperate with each other with a view to resolving the dispute between themselves before referring it for determination. Either the contractor or the Health Board may, if it wishes to do so, invite the GP sub-committee of the area medical committee to participate in these discussions.

### ***Protocol in respect of locum cover payments***

21.13 Part 4 sets out a number of circumstances in which Health Boards are obliged to pay a maximum amount per week for locum cover in respect of an absent performer. However, even where a Health Board is not directed pursuant to this SFE to make payments in respect of such cover, it has powers to do so as a matter of discretion – and may also decide, as a matter of discretion, to make top-up payments in cases where the maximum directed amount is payable.

21.14 As a supplementary measure, Health Boards are directed to adopt and keep-up-to-date a protocol, which they must take all reasonable steps to agree with any relevant GP sub-committee of the area medical committee, setting out in reasonable detail–

- (a) how they are likely to exercise their discretionary powers to make payments (including top-up payments) in respect of locum cover,



- having regard to the budgetary targets they have set for themselves, where they are not obliged to make such payments;
- (b) where they are obliged to make payments in respect of locum cover pursuant to Part 4, the circumstances in which they are likely to make payments in respect of locum cover of less than the maximum amount payable (for example where the locum cover is in respect of a part-time GP performer who normally works three days per week);
  - (c) how they are likely to exercise their discretionary powers to make payments in respect of cover for absent GP performers which is provided by nurses or other health care professionals;
  - (d) how they are likely to exercise their discretionary powers to make payments to a partner or shareholder in a contractor, or an employee of a contractor, who is providing locum cover for an absent GP performer who is also a partner or shareholder in, or an employee of, the contractor;
  - (e) how they are likely to exercise their discretionary powers to make payments in respect of a GP performer who is on long term sickness leave, where locum cover payments are no longer payable in respect of him under Section 10. In determining the amounts that may be appropriate in these circumstances, the expectation of the Scottish Government Health Directorate is that they would not exceed the half rate payable in the second period of 26 weeks under paragraph 10.6(b), or the amount that would be payable under the NHS Superannuation Scheme (Scotland) Regulations if the performer retired on grounds of permanent incapacity, whichever is the lower; and
  - (f) where they are not obliged to make payments in respect of locum cover pursuant to Part 4, how they are likely to exercise their discretionary powers to make payments in respect of a sole practitioner who is absent for the purposes of attending an accredited postgraduate educational course, in circumstances where, because of the nature of the locality in which the contractor's premises are situated, locum cover arrangements (i.e. arrangements other than cover provided by a neighbouring practice) are essential to meet the needs of patients in that locality for primary medical services .

Where a Health Board departs from that protocol in any individual case and refuses an application for funding in respect of locum cover, this must be duly justified to the unsuccessful applicant.

### ***Adjustment of Contractor Registered Populations***

21.15 The starting point for the determination of a contractor's Contractor Registered Population is the number of patients recorded by PSD of NHS National Services Scotland as being registered with the contractor, initially when its GMS contract takes effect and thereafter at the start of each quarter, when a new number must be established.

21.16 However, in respect of any quarter, this number may be adjusted as follows–

- (a) if a contractor satisfies a Health Board that a patient who registered with it before the start of a quarter was not included in the number of patients recorded by PSD of NHS National Services Scotland as being registered with it at the start of that quarter, and the Health Board received notification of the new registration within 48 hours of the start of that quarter, that patient–
  - (i) is to be treated as part of that contractor’s Contractor Registered Population at the start of that quarter, and
  - (ii) if he was registered with another of the Health Board’s contractors at the start of that quarter, is not to be counted as part of that other contractor’s Contractor Registered Population for that quarter;
  
- (b) if, included in the number of patients recorded by PSD of NHS National Services Scotland as being registered with a contractor at the start of a quarter, there are patients who–
  - (i) transferred to another contractor in the quarter before the previous quarter (or earlier), but
  - (ii) notification of that fact was not received by the Health Board until after the second day of the previous quarter,those patients are not to be treated as part of the contractor’s Contractor Registered Population at the start of that quarter;
  
- (c) if a patient is not recorded by PSD of NHS National Services Scotland as being registered with a contractor at the start of a quarter, but that patient–
  - (i) had been removed from a contractor’s patient list in error, and
  - (ii) was reinstated in the quarter before the previous quarter (or earlier),that patient is to be treated as part of the contractor’s Contractor Registered Population at the start of that quarter.

21.17 If a contractor wishes its Contractor Registered Population to be adjusted in accordance with paragraph 21.16, it must–

- (a) within 10 days of receiving from the Health Board a statement of its patient list size for a quarter, request in writing that the Health Board makes the adjustment; and

- (b) within 21 days of receiving that statement, provide the Health Board with the evidence upon which it wishes to rely in order to obtain the adjustment.

and the Health Board must seek to resolve the matter as soon as is practicable. If there is a dispute in connection with the adjustment, paragraphs 21.11 and 21.12 apply.

***Default contracts and payments to persons not able to enter into default contracts***

21.18 If a contractor's GMS contract was agreed after 1st April 2005 but the contract takes effect for payment purposes on 1st April 2004, that contractor has received a payment under a default contract or pursuant to article 41(1) of the 2004 Order, and that payment could have been made \_

- (a) as a payment on account under the contractor's GMS contract pursuant to paragraph 21.6, it shall be treated as a payment on account pursuant to paragraph 21.6 (and for these purposes a payment of one twelfth of a final global sum equivalent under a default contract or under article 41(1) of the 2004 Order shall be treated as a payment on account in respect of a Payable GSMP); and
- (b) as a payment under the contractor's GMS contract pursuant to Part 4 or 5 of this SFE, it shall be treated as a payment under the contractor's GMS contract pursuant to Part 4 or 5 of this SFE,

and accordingly, any condition that attaches to such a payment by virtue of this SFE is attached to that payment.

21.19 In these circumstances, the payments that a contractor is entitled to receive under its GMS contract pursuant to this SFE that are or were due to fall due before the end of the first quarter of the financial year 2005 to 2006 are instead to fall due at the end of that quarter, unless—

- (a) the GMS contract is agreed between 1st June 2005 and 1st September 2005, in which case they are instead to fall due at the end of the second quarter of the financial year 2005 to 2006, as are all the payments that are or were due to fall due pursuant to this SFE in the second quarter;
- (b) the GMS contract is agreed between 1st September 2005 and 1st December 2005, in which case they are instead to fall due at the end of the third quarter of the financial year 2005 to 2006, as are all the payments that are or were due to fall due pursuant to this SFE in that third quarter or in the second quarter of that financial year; or
- (c) the GMS contract is agreed between 1st December 2005 and the end of the financial year, in which case they are to fall due at the end of the financial year, as are all the other payments that are or were due to fall due pursuant to this SFE before the end of the financial year.

## 22. Superannuation contributions

### *Health Boards' responsibilities in respect of contractors' employer's and employee's superannuation contributions*

22.1 Employer's superannuation contributions in respect of GP Registrars – who are subject to separate funding arrangements from those in respect of other GP performers – are the responsibility of NHS Boards, which act as their employer for superannuation purposes.

22.2 Under the NHS Superannuation Scheme (Scotland) Regulations, contractors continue to be responsible for paying employer's superannuation contributions of practice staff who are members of the NHS Superannuation Scheme (Scotland), and for collecting and forwarding to the Scottish Public Pensions Agency both employer's and employee's superannuation contributions in respect of their practice staff. With effect from 1st April 2004, contractors also have become responsible for paying to the Scottish Public Pensions Agency both the employer's and employee's superannuation contributions for–

- (a) non-GP providers;
- (b) GP performers who are not GP Registrars; and
- (c) Assistant Practitioners

who are members of the NHS Superannuation Scheme (Scotland). The detail of all these arrangements is set out in the NHS Superannuation Scheme (Scotland) Regulations.

22.3 In this Section non-GP providers and GP performers who are not GP Registrars are together referred to as “Pension Scheme Contributors”;

22.4 The cost of paying Pension Scheme Contributors' employer's and employee's superannuation contributions relating to the income of Pension Scheme Contributors which is derived from the revenue of a GMS contract has been or will be included in the national calculations of the levels of the payments in respect of services set out in this SFE. It is also to be assumed that–

- (a) any other arrangements that the contractor has entered into to provide services which give rise to NHS pensionable profits for the purposes of the NHS Superannuation Scheme (Scotland) Regulations will have included provision for all the payable superannuation contributions in respect of its Pension Scheme Contributors in the contract price ; and
- (b) the payments from the NHS Board (or PSD on its behalf) to the contractor in respect of services under the GMS contract, together with the contract price of any other contract to provide services which give rise to NHS pensionable profits for the purposes of the NHS

Superannuation Scheme (Scotland) Regulations that the contractor has entered into, also cover the cost of any additional voluntary contributions that the NHS Board (or PSD on its behalf) is obliged, to forward to the Scottish Public Pensions Agency or an Additional Voluntary Contributions Provider on the contractor's, or its Pension Scheme Contributors', behalf.

22.5 Accordingly, the costs of paying the employer's and employee's superannuation contributions of a contractor's Pension Scheme Contributors under the NHS Superannuation Scheme (Scotland) in respect of their NHS pensionable profits from all sources – unless superannuated for the purposes of the NHS Superannuation Scheme (Scotland) elsewhere, for example, under a contract of employment with a NHS Board – are all to be deducted by PSD from the monies paid to the contractor, pursuant to this SFE.

***Monthly deductions in respect of superannuation contributions***

22.6 The deductions are to be made in two stages. First, PSD must, as part of the calculation of the net amount of a contractor's monthly payments under this SFE, deduct an amount that represents a reasonable approximation of a monthly proportion of–

- (a) the contractor's liability for the financial year in respect of the employer's superannuation costs under the NHS Superannuation Scheme (Scotland) relating to any of the contractor's Pension Scheme Contributors (i.e a reasonable approximation in respect of their total NHS Superannuation Scheme (Scotland) NHS pensionable profits which are not superannuated elsewhere) who are members of the NHS Superannuation Scheme (Scotland);
- (b) those Pension Scheme Contributors' related employee's superannuation contributions (including added years contributions); and
- (c) any payable Money Purchase Additional Voluntary Contributions in respect of those Pension Scheme Contributors.

Before determining the monthly amount to be deducted, PSD must take reasonable steps to agree with the contractor what that amount should be, and it must duly justify to the contractor the amount that it does determine as the monthly deduction.

22.7 Superannuation contributions in respect of payments for specific purposes which are paid after the start of the financial year will, for practical reasons, need to be handled slightly differently. The relevant NHS Board and the contractor may agree that the payment is to be made net of any superannuation contributions that the Health Board is responsible for collecting on behalf of the Scottish Public Pensions Agency or an Additional Voluntary Contributions Provider. In the absence of such an agreement, the default position is that the contribution will be calculated as part of the finalisation of the pension contributions for the financial year and the contributions

will actually be deducted from payments made to the practice in the following financial year.

22.8 An amount equal to the monthly amount that PSD (or the NHS Board where pensioned separately) deducts must be remitted to the Scottish Public Pensions Agency and any relevant Money Purchase Additional Voluntary Contributions Providers no later than –

- (a) the 19th day of the month after the month in respect of which the amount was deducted; or
- (b) in the case of Money Purchase Additional Voluntary Contributions, 7 days after an amount in respect of them is deducted pursuant to paragraph 22.6 (c).

### ***End-year adjustments***

22.9 After the end of any financial year, including after the end of the financial year 2004 to 2005, the final amount of each Pension Scheme Contributor's superannuable income in respect of the financial year will need to be determined. For these purposes, the superannuable income of a Pension Scheme Contributor is his total NHS pensionable profits, as determined in accordance with the NHS Superannuation Scheme (Scotland) Regulations.

22.10 As regards contractors that are partnerships, sole practitioners or companies limited by shares, it is a condition of all the payments payable pursuant to Parts 1 to 3 of this SFE – if any of the contractor's Pension Scheme Contributors are members of the NHS Superannuation Scheme (Scotland) – that the contractor ensures that its Pension Scheme Contributors (other than those who are neither members of the NHS Superannuation Scheme (Scotland) nor due Seniority Payments) prepare, sign and forward to PSD -

- (a) an accurately completed certificate, the General Medical Practitioner's Annual Certificate of Pensionable Profits, in the standard format provided nationally; and
- (b) no later than one month from the date on which the GP was required to submit the HM Revenue and Customs return on which the certificate must be based.

22.11 Seniority Payments have to be separately identifiable in the certificate for the purposes of confirming the amount of GP providers' Seniority Payments. Seniority Payment figures in the certificates forwarded to PSD will necessarily be provisional (unless they are submitted too late for the information they contain to be included in the national calculation of Average Adjusted Superannuable Income), but the forwarding of certificates must not be delayed simply because of this. Pension Scheme Contributors who are not members of the NHS Superannuation Scheme (Scotland) but in respect of whom a claim for a Quarterly Seniority Payment is to be made must nevertheless prepare, sign and forward the certificate to the Health Board so that the correct amount of their Seniority Payments may be determined.

22.12 Once a contractor's Pension Scheme Contributors' superannuable earnings in respect of a financial year have been agreed, PSD must–

- (a) if its deductions (whether pursuant to this SFE or the 2004/05 SFE) from the contractor's payments under the SFE for the relevant financial year relating to the superannuation contributions in respect of those earnings–
  - (i) did not cover the cost of all the employer's and employee's superannuation contributions that are payable by the contractor or the Pension Scheme Contributors in respect of those earnings–
    - (aa) deduct the amount outstanding from any payment payable to the contractor under its GMS contract pursuant to this SFE (and for all purposes the amount that is payable in respect of that payment is to be reduced accordingly), or
    - (bb) obtain payment (where no such deduction can be made) from the contractor of the amount outstanding, and it is a condition of the payments made pursuant to this SFE that a contractor that is an employing authority of a Pension Scheme Contributor must pay to the Contributor's relevant NHS Board the amount outstanding, or
  - (ii) were in excess of the amount payable by the contractor and the Pension Scheme Contributor to the Scottish Public Pensions Agency in respect of those earnings, repay the excess amount to the contractor promptly and
- (b) forward any outstanding employer's and employee's superannuation contributions due in respect of those earnings to the Scottish Public Pensions Agency (having regard to the payments it has already made on account in respect of those Pension Scheme Contributors for that financial year).

### ***Locums***

22.13 There are different arrangements for superannuation contributions of locums, and these are not covered by this SFE.

# ANNEX A

## GLOSSARY

### PART 1

#### ACRONYMS

The following acronyms are used in this document:

CFMP – Correction Factor Monthly Payment  
CPI – Contractor Population Index  
CRP – Contractor Registered Population  
CWP – Contractor Weighted Population  
FYOIP – Five-Year-Olds Immunisation Payment  
GMS – General Medical Services  
GSE – Global Sum Equivalent  
GSMP – Global Sum Monthly Payment  
LMC – Local Medical Committee  
MPIG – Minimum Practice Income Guarantee  
NHS – National Health Service  
QOF – Quality and Outcomes Framework  
TYOIP – Two-Year-Olds Immunisation Payment

### PART 2

#### DEFINITIONS

Unless the context otherwise requires, words and expressions used in this SFE and the 2004 Regulations bear the meaning they bear in the 2004 Regulations.

The following words and expressions used in this SFE have, unless the context otherwise requires, the meanings ascribed below.

“The 1978 Act” means the National Health Service (Scotland) Act 1978. This Act was significantly amended (for the purposes of this SFE) by the Primary Medical Services (Scotland) Act 2003

“The 2004 Regulations” means the National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004.

“The 2004/5 SFE” means the Statement of Financial Entitlements under section 17M of the 1978 Act in respect of the financial year 2004 to 2005.

“Achievement Payment” is to be construed in accordance with Section 6.

“Aspiration Payment” is to be construed in accordance with Section 5.



“Aspiration Points Total” is to be construed in accordance with paragraph 4.2(b) and 5.11.

“Additional Services”, in the context of the additional services domain, means the following services: cervical screening services, child health surveillance, maternity medical services and contraceptive services. In other contexts, it also includes: minor surgery, childhood immunisations and pre-school boosters, and vaccinations and immunisations.

“Additional or Out-of Hours Services” means all the services listed in the definition of Additional Services above, together with out-of-hours services provided under arrangements made pursuant to regulation 30 of the 2004 Regulations.

“Adjusted Global Sum Equivalent” is to be construed in accordance with paragraphs 3.2 and 3.3.

“Adjusted Global Sum Monthly Payment” is to be construed in accordance with paragraphs 2.5 and 2.10.

“Adjusted Practice Disease Factor” is to be construed in accordance with paragraph 6.5(a) and Annex F. “Childhood Immunisations and Pre-school Boosters” is to be construed as a reference to the Childhood Vaccinations and Immunisations additional service referred to in the 2004 Regulations.

“Contractor” means a person entering into, or who has entered into, a GMS contract with a Health Board.

“Contractor Population Index” is to be construed in accordance with paragraph 2.18.

“Contractor Registered Population”, in relation to a contractor, means – subject to any adjustment made in accordance with paragraph 21.16 – the number of patients recorded by PSD of NHS National Services Scotland as being registered with the contractor, initially when its GMS contract takes effect and thereafter at the start of each quarter, when a new number must be established.

“Contractor Weighted Population for the Quarter” is a figure set for each contractor arrived at by the Global Sum Allocation Formula in Annex B.

“Correction Factor Monthly Payment” is to be construed in accordance with paragraph 3.9.

“Default contract” means a contract entered into under section 7(1) of the Primary Medical Services (Scotland) Act 2004.

“DES Directions” means the Primary Medical Services (Directed Enhanced Services) (Scotland) Directions 2011.

“Employed or engaged”, in relation to a medical practitioner’s relationship with a contractor, includes—

- (a) a sole practitioner who is the contractor;
- (b) a medical practitioner who is a partner in a contractor that is a partnership; and
- (c) a medical practitioner who is a shareholder in a contractor that is a company limited by shares.

“Employing authority” has the same meaning as in the NHS Superannuation Scheme (Scotland) Regulations.

“Final Global Sum Equivalent” is to be construed in accordance with paragraph 3.4

“Full-time” means, in relation to a performer of primary medical services with a contract of employment, a contractual obligation to work for at least 37½ hours per normal working week. In relation to a performer without a contract of employment (which is only relevant in the context of Golden Hello payments), it means an equivalent working commitment of at least 37½ hours per normal working week. The hours total may be made up surgeries, clinics, administrative work in connection with the performance of primary medical services, or management activities and other similar duties which enhance the performance of the contractor as a provider of primary medical services but do not directly relate to the performance of primary medical services.

““General Practitioner” means—

- (a) a medical practitioner whose name is included in the General Practitioner Register kept by the General Medical Council.
- (b) until the coming into force of the said article 10, a medical practitioner who is either—
  - (i) until the coming into force of paragraph 22 of Schedule 8 to the 2003 Order, suitably experienced within the meaning of section 31(2) of the National Health Service Act 1977 , section 21 (2) of the National Health Service (Scotland) Act 1978 or Article 8(2) of the Health and Personal Social Services (Northern Ireland) Order 1978, or
  - (ii) upon the coming into force of paragraph 22 of Schedule 8 to the 2003 Order, an eligible general practitioner pursuant to that paragraph other than by virtue of an acquired right under paragraph 1(d) of Schedule 6 to the 2003 Order.

“Global Sum Equivalent” is to be construed in accordance with paragraph 3.2

“GMS contract” means a general medical services contract under section 17J of the 1978 Act.

“GMS contractor” means a contractor who provides primary medical services under a GMS contract.

“GP performer” means a general practitioner–

- (a) whose name is included in a medical performers’ list of a Health Board; and
- (b) who performs medical services under a GMS contract, and who is–
  - (i) himself a GMS contractor (i.e. a sole practitioner); or
  - (ii) an employee of, a partner in or a shareholder in the contractor.

“GP provider” means a GP who is–

- (a) himself a GMS contractor (i.e. a sole practitioner);
- (b) a partner in a partnership that is a GMS contractor, or
- (b) a shareholder in a company limited by shares that is a GMS contractor.

“GP registrar” has the same meaning as in Regulation 2 of the National Health Service (Primary Medical Services Performers Lists)(Scotland) Regulations 2004.

“Health Board’s cut-off date for calculating quarterly payments” means the date in the final month of a quarter, determined by a Health Board, after which it is not in a position to accept new data in respect of payments to be made at the end of that quarter.

“Historic Opt-Outs Adjustment” is to be construed in accordance with paragraphs 3.6 and 3.7.

“Initial Global Sum Equivalent” is to be construed in accordance with paragraphs 3.2 and 3.3.

“Initial Global Sum Monthly Payment” is to be construed in accordance with paragraphs 2.4 and 2.9.

“Medical Performers List” is to be construed in accordance with regulation 4(1) of the Performers List Regulations

“Minimum Practice Income Guarantee” is to be construed in accordance with paragraph 3.1

“Money Purchase Additional Voluntary Contributions Provider” is an “authorised provider” as defined in section 10(6) of the Superannuation Act 1972.

“Money Purchase Additional Voluntary Contributions” means voluntary contributions made by a member of an occupational pension scheme over and above his or her normal contributions.

“Monthly Aspiration Payment” is to be construed in accordance with paragraphs 5.7 and 5.12.

“NHS Pension Scheme Regulations” means the National Health Service Superannuation Scheme (Scotland) Regulations 1995, as amended.

“Non-GP provider” has the same meaning as in the NHS Superannuation Scheme (Scotland) Regulations.

“Part-time” means, in relation to a performer of primary medical services with a contract of employment, a contractual obligation to work for less than 37½ hours per normal working week. In relation to a performer without a contract of employment (which is only relevant in the context of Golden Hello payments), it means an equivalent working commitment which is less than 37½ hours per normal working week. The hours total may be made up surgeries, clinics, administrative work in connection with the performance of primary medical services, or management activities and other similar duties which enhance the performance of the contractor as a provider of primary medical services but do not directly relate to the performance of primary medical services.

“Payable Global Sum Monthly Payment” is to be construed in accordance with paragraphs 2.6 and 2.11.

“Pension Scheme Contributor” shall be construed in accordance with paragraph 22.3.

“Performers List Regulations” means the National Health Service (Primary Medical Services Performers List) (Scotland) Regulations 2004.

“PMS contract” means section 17C arrangements.

“PMS contractor”, except where the context otherwise indicates means a section 17C provider.

“Provisional Achievement Payment” is to be construed in accordance with paragraphs 5.4 and 5.5.

“Quality and Outcomes Framework” is the framework reproduced at Annex E.

“Quality and Outcomes Framework Uprating Index” is to be construed in accordance with paragraph 5.6.

“Quarter” means a quarter of the financial year.

“Reckonable Service” is to be construed in accordance with paragraph 13.3.

“Red Book” means the Statement of Fees and Allowances under regulations 35 and 36 of the National Health Service (General Medical Services) (Scotland) Regulations 1995, as it had effect on 31st March 2004. However, for the purposes of paragraph 13.3(e)(ii)(aa) and 13.13(a), it means the Statement of Fees and Allowances under regulations 35 and 36 of the National Health Service (General Medical Services) (Scotland) Regulations 1995, as it had effect on 31st March 2003.

“Sole practitioner” means a GP performer who is himself a contractor.

“Suspended”, in relation to a GP performer, means suspended from a medical performers list.

“Target Population Factor is to be construed in accordance with paragraphs F3 and F4.

“Temporary Patients Adjustment” is to be construed in accordance with paragraph 2.4 and Annex C.

“Time Commitment Fraction” is the fraction produced by dividing a performer of primary medical services’ actual working commitment by 37½ hours. The hours total may be made up of surgeries, clinics, administrative work in connection with the performance of primary medical services, or management activities and other similar duties which enhance the performance of the contractor as a provider of primary medical services but do not directly relate to the performance of primary medical services.

“Unadjusted Achievement Payment” is to be construed in accordance with paragraph 5.4.

“Uprating Percentage” is to be construed in accordance with paragraph 3.12.

## ANNEX B

### THE SCOTTISH ALLOCATION FORMULA (SAF) FOR GENERAL MEDICAL SERVICES

#### Introduction

B.1. The following note is an explanation of the **Scottish Allocation Formula (SAF)** for General Medical Services (GMS) which forms part of the contract.

B.2. The SAF is a formula that allocates resources to GP practices on the basis of the relative needs and workload of their patients, taking into consideration the relative costs of service delivery. The SAF is responsible for the allocation of a **global sum** to each practice. The global sum accounts (on average) for **50-55 per cent** of a practices' current fees and allowances in Scotland. The remainder of the resources available to GMS flows through NHS boards (including premises, IT and seniority), the Quality and Outcomes Framework (QOF), enhanced services, and the Minimum Practice Income Guarantee (MPIG).

#### The Scottish Allocation Formula

B.3. The Scottish Allocation Formula (SAF) determines how the global sum in Scotland is distributed between GP practices; **it does not inform the total size of the Scottish budget for the global sum**. The SAF is a population-based formula at GP practice level with a series of **'weightings'** to reflect the relative needs of GMS patients and the additional costs of providing an adequate service in remote and rural areas of Scotland. The components of the SAF are:

- The **GP practice population** (total practice list size).

Adjusted for 'weightings' to reflect:

- The **age and sex structure** of the practice population (demography).
- The **additional need** of the practice population (morbidity and deprivation).
- The **rurality and remoteness** of the practice population.

There are other weights - set at a UK level - to take account of the larger workload in regard to care home patients and new registrations. A further adjustment allows for differences in staff costs between health board areas.

#### GP Practice Population

B.4. The SAF uses the **registered list** of each practice as the basis for the GP practice population.

#### Demography

B.5. The relative need for GMS will to a significant extent depend on the **age and sex structure** of the GP practice population. The population groups that are relatively

intensive users of GP services are children, young women and older patients. The SAF includes a series of age and sex ‘weightings’ to allocate a greater share of resources to practices with greater proportions of high-user patient groups than the Scottish average. These ‘weightings’ are summarised in the following table:

	0-4	5-14	15-24	25-44	45-64	65-74	75-84	85+
Male	2.86	1.00	1.28	1.52	2.17	3.42	4.45	4.91
Female	2.51	1.21	2.71	2.89	3.17	3.81	4.66	5.09

Note that the SAF age-sex ‘weightings’ are based on 2004/05 year data from the **Practice Team Information (PTI)** practices<sup>8</sup> and are expressed relative to a male patient aged 5-14.

### Additional Need

B.6. The relative need for GMS will also depend on the **socio-economic status** of the GP practice population. People from deprived backgrounds typically have poorer health outcomes, higher morbidity and greater health needs. The SAF includes an **index of deprivation and mortality** to ‘weight’ the GP practice population on the basis of the following indicators:

- The unemployment rate.
- The proportion of elderly people claiming income support.
- The standardised mortality rate amongst people under the age of 65.
- Households with two or more indicators of deprivation.

A GP practice population with a higher proportion of high user patient groups - as defined by the above set of indicators - will receive a greater additional need ‘weighting’ under the SAF. The exact nature of the formula that ‘weights’ a practice list for deprivation and mortality is:

$$\text{Practice List} * [(0.92 * (109.04 + 3.09 * \text{Index}) + (0.08 * (82.46 + 4.89 * \text{Index}))]$$

Where, *Index* denotes the index of deprivation and mortality. Note that this adjustment is also split between 92 per cent surgery contacts and 8 per cent home contacts.

### Remote and Rural Areas

B.7. The costs of providing GMS in **remote and rural locations** are generally greater (per patient) than in urban population centres. The SAF therefore attempts to reflect this by ‘weighting’ practices for their remoteness and rurality. The three indicators that are used to reflect remoteness and rurality in the SAF are:

- The population density (hectares per resident) of the GP practice population.

<sup>8</sup> Approximately 45 practices in Scotland provide monthly consultation returns to the PTI database.

- The population sparsity (the percentage of the population living in settlements of less than 500 residents) of the GP practice population.
- The percentage of patients in the GP practice population attracting road mileage payments.

The exact nature of the formula that ‘weights’ a practice list for remoteness and rurality is:

$$\text{Practice List} * [54.54 + 1.88 * \text{Population Density} + 0.14 * \text{Population Scarcity} + 0.11 * \text{Road Mileage Payments}]$$

This adjustment recognises the extra costs incurred in providing GMS services in remote and rural areas.

### The Weighted Practice Population

B.8. The ‘**weighted**’ practice population or list is the registered GP practice population adjusted to reflect the Scottish ‘weights’ for age-sex, additional need and remoteness and rurality. The following *illustrative* example shows how the adjustments for age-sex, additional need and remoteness and rurality impact on the GP practices’ final allocation.

B.9. Suppose we have two practices A and B:

- Practice A is a small practice with 2,000 registered patients.
- Practice B is larger with 8,000 registered patients.

Practice A is in a poorer rural area, which is serving an ageing population. Practice B is located in an affluent urban area, serving a relatively young population. If a budget of £10,000 was divided between practices A and B on the basis of their registered lists, then practice A would receive £2,000 and practice B £8,000.

B.10. However, the basis for the allocation is **not** the registered but the ‘weighted’ lists of the two practices, A and B. Possible adjustments for practices A and B are shown in the following table:

## Table - Illustrated Example

	Practice A	Practice B	Total
<b>Registered List</b>	<b>2,000</b>	<b>8,000</b>	<b>10,000</b>
Age-Sex Adjustment	1.10	0.98	-
Deprivation Adjustment	1.15	0.95	-
Remote/Rural Adjustment	1.15	0.95	-
<b>Weighted List</b>	<b>2,910</b>	<b>7,090</b>	<b>10,000</b>



The ‘weighted’ list for practice A is equal to  $(2,000 \times 1.10 \times 1.15 \times 1.15 = 2,910$  ‘weighted’ patients) and for practice B the relevant calculation is  $(8,000 \times 0.98 \times 0.95 \times 0.95 = 7,090$  ‘weighted’ patients). Practice A with 2,910 ‘weighted’ patients receives an increase in its allocation of £910. Practice B’s final allocation falls to £7,090.

B.11. The effect on the allocations for practices A and B is that £910 has been redistributed from practice B to practice A compared with what they would have received on the basis of their registered lists. **Therefore, it is on the basis of the ‘weighted’ list that a practice’s indicative allocation for its share of the Scotland-wide global sum has been calculated.**

### **Minimum Practice Income Guarantee (MPIG)**

B.12. The minimum practice income guarantee (MPIG) applies to all Scottish GP practices that qualify for this funding supplement. The method of calculation of MPIG in Scotland is identical to the rest of the UK, the only difference is that Scottish practices’ indicative allocations are based on the Scottish Allocation Formula. Any practice in Scotland with an indicative allocation, which is less than their equivalent **global sum** fees and allowances receives the MPIG.

### **Summary**

B.13. In summary the main points are that:

- The Scottish Allocation Formula (SAF) is a **population-based formula** that allocates resources according to **relative patient need** for GMS. The SAF allocates a **global sum** for each practice in Scotland.
- The SAF uses **registered** practice population data, **‘weighted’** for variations in **demography, deprivation and remoteness and rurality** between GP practice populations. The ‘weighted’ list is used to calculate the share of global sum resources that are allocated to the GP practice.

## ANNEX C

### TEMPORARY PATIENTS ADJUSTMENT

C.1 The need for this arises because of GPs' obligations to provide emergency treatment to people who are not registered with their practice and to provide treatment to temporary residents. Previously, this treatment was paid for by the temporary residents fees, emergency treatment fees and immediately necessary treatment fees under the Red Book, but these fees have been discontinued. The Temporary Patients Adjustment will be calculated as follows.

C.2 All contractors are to receive a payment for unregistered patients as an element in their global sum allocation. The amount each contractor receives in respect of such patients is generally to be based on the average amount that, historically, the contractor's practice has claimed in respect of treating such patients each year under the Red Book prior to 1st April 2003.

C.3 In the case of a contractor in respect of which a Temporary Patients Adjustment was calculated for the financial year prior to the current financial year in respect of which a calculation needs to be made, the Temporary Patients Adjustment for the current financial year will be the same amount as was calculated for the previous financial year.

C.4 However, there may be exceptional cases where a calculation pursuant to paragraph C.3 produces an amount that is clearly inappropriate as the basis for a payment in the financial year 2004 to 2005. This may occur, for example, where the practice has faced a significant increase or decrease in the numbers of unregistered patients requiring treatment from it. In these cases, the Health Board is instead to determine for the contractor, as the basis for its Temporary Patients Adjustment, a reasonable annual amount which is an appropriate rate for the area where the practice is located.

C.5 In the case of a contractor in respect of which no Temporary Patients Adjustment was calculated for the financial year prior to the current financial year in respect of which a calculation needs to be made, the NHS Board is instead to determine for the contractor, as the basis for its Temporary Patient Adjustment for the current financial year, a reasonable annual amount which is an appropriate rate for the area where the practice is located. Before making such a determination, the NHS Board must discuss the matter with the contractor.

C.6 The amount calculated in accordance with paragraphs C.3 to C.5 is the annual amount of the contractor's Temporary Patients Adjustment, which is the amount to be included in its Initial GSMP calculation.

C.7 Once a Temporary Patients Adjustment has been determined, it remains unchanged.

# ANNEX D - NOT ALLOCATED

# ANNEX E

## QUALITY AND OUTCOMES FRAMEWORK

### GUIDANCE

#### Section 1. Principles

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

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

#### Section 2. Clinical indicators

##### 2.1 General format

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

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

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

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

Indicators across all disease categories are numbered. In the guidance they are prefixed by the disease category to which they belong e.g. chronic heart disease (CHD) indicator number one, becomes CHD1. Indicator 'identifiers' or 'references' are numbered sequentially except where indicators have been removed or amended.

Where indicators have been amended, either in relation to the activity being measured, the frequency with which the activity should be completed or where a linked indicator has been changed, the indicator has been renumbered. For example the 2009/10 diabetes DM23 HbA1c target changed in 2011/12, therefore, the indicator identifier changed to DM26. For clarity DM24 and DM25 were also renumbered to keep the three target indicators grouped together.

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

The term PCO (Primary Care Organisation) is used throughout, as the structures responsible for the organisation and management of primary care differ in the four countries. In Scotland the term is used to mean Health Board.

For each indicator, two descriptions are given – 'rationale' and 'reporting and verification'

### **2.1.1. 'xx.1 Rationale'**

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

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

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

In many of the indicators additional time is factored in to the timeframe, either within the wording of the indicator (e.g. BP5) or through the supporting business logic (DEP4). The first recognises that in practice it may be difficult to ensure that all patients have attended for review and have completed the review process within any particular timescale. For example, in relation to indicator BP5, national guidance recommends that all patients with hypertension should have their blood pressure measured every six months. However, the indicator wording looks at the number of patients with hypertension who have had a blood pressure measured in the last nine months. The second recognises that QOF activity can span more than one QOF year thereby ensuring fair and consistent payments to practices and ensuring that patients who are diagnosed or newly registered within the last three months of the QOF year are identified.

### **2.1.2. 'xx.2 Reporting and verification'**

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

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

Reporting should be possible through the use of GP clinical systems and practices can run a report annually which can be submitted to the PCO.

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

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

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

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

## **2.2. Logical Query Indicator Specification and the Dataset and Business Rules**

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

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

## **2.3. Exception reporting**

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

The following criteria have been agreed for exception reporting:

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

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

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

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

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

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

Exception reporting guidance can be found at the following location:

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

## 2.4. Disease registers

An important feature of the QOF is the establishment of disease registers. While it is recognised that these may not be completely accurate, it is the responsibility of the practice to demonstrate that it has systems in place to maintain a high quality register. Verification visits may involve asking how the practice constructed the register and how the register is maintained. PCOs will compare the reported prevalence with the

expected prevalence. This is a relatively blunt instrument and there are likely to be good reasons for variations but it is anticipated these will be discussed with practices. An explanation on how points are calculated and how prevalence will be applied can be found in Annex G.

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

## **Section 3. Organisational, Patient Experience and Additional Services indicators**

### **3.1. General format**

The organisational, patient experience and additional services domain indicators include indicator wording along with information in the following areas to support the indicator:

- practice guidance
- written evidence/reporting and verification
- assessment visit
- assessors guidance

The introduction to the organisational domain goes into further detail on the above areas.

Please note exception reporting does not apply to the organisational and patient experience indicators. It does, however, apply to indicators in the additional services domain.



## Summary of indicators - Clinical domain

### Secondary prevention of coronary heart disease

Indicator	Points	Payment stages
<b>Records</b>		
CHD1. The practice can produce a register of patients with coronary heart disease	4	
<b>Diagnosis and initial management</b>		
<i>CHD13. For patients with newly diagnosed angina (diagnosed after 1 April 2011), the percentage who are referred for specialist assessment</i> <i>NICE menu ID: NM08</i>	7	40–90%
<b>Ongoing management</b>		
CHD6. The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 or less	17	40-71%
CHD8. The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 15 months) is 5mmol/l or less	17	40-70%
CHD9. The percentage of patients with coronary heart disease with a record in the preceding 15 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken (unless a contraindication or side-effects are recorded)	7	40-90%
CHD10. The percentage of patients with coronary heart disease who are currently treated with a beta-blocker (unless a contraindication or side-effects are recorded)	7	40-60%
CHD14. The percentage of patients with a history of myocardial infarction (from 1 April 2011) currently treated with an ACE inhibitor (or ARB if ACE intolerant), aspirin or an alternative anti-platelet therapy, beta-blocker and statin (unless a contraindication or side-effects are recorded) <i>NICE menu ID: NM07</i>	10	40-80%
CHD12. The percentage of patients with coronary heart disease who have a record of influenza immunisation in the preceding 1 September to 31 March	7	40-90%

## Cardiovascular disease – primary prevention

Indicator	Points	Payment stages
<b>Initial diagnosis</b>		
PP1. In those patients with a new diagnosis of hypertension (excluding those with pre-existing CHD, diabetes, stroke and/or TIA) recorded between the preceding 1 April to 31 March: the percentage of patients aged 30 to 74 years who have had a face to face cardiovascular risk assessment at the outset of diagnosis (within three months of the initial diagnosis) using an agreed risk assessment tool <i>NICE menu ID: NM06</i>	8	40-70%
<b>Ongoing management</b>		
PP2. The percentage of people diagnosed with hypertension (diagnosed after 1 April 2009) who are given lifestyle advice in the preceding 15 months for: increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet	5	40-70%

## Heart failure

Indicator	Points	Payment stages
<b>Records</b>		
HF1. The practice can produce a register of patients with heart failure	4	
<b>Initial diagnosis</b>		
HF2. The percentage of patients with a diagnosis of heart failure (diagnosed after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment	6	40-90%
<b>Ongoing management</b>		
HF3. The percentage of patients with a current diagnosis of heart failure due to Left Ventricular Dysfunction (LVD) who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker (ARB), who can tolerate therapy and for whom there is no contraindication	10	40-80%
HF4. The percentage of patients with a current diagnosis of heart failure due to LVD who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker, who are additionally treated with a beta-blocker licensed for heart failure, or recorded as	9	40-60%

intolerant to or having a contraindication to beta-blockers.		
--	--	--

## Stroke and Transient Ischaemic Attack (TIA)

Indicator	Points	Payment stages
<b>Records</b>		
STROKE 1. The practice can produce a register of patients with stroke or TIA	2	
STROKE 13. The percentage of new patients with a stroke or TIA who have been referred for further investigation	2	40-80%
<b>Ongoing management</b>		
STROKE 6. The percentage of patients with a history of TIA or stroke in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 or less	5	40-71%
STROKE 7. The percentage of patients with TIA or stroke who have a record of total cholesterol in the preceding 15 months	2	40-90%
STROKE 8. The percentage of patients with TIA or stroke whose last measured total cholesterol (measured in the preceding 15 months) is 5mmol/l or less	5	40-60%
STROKE 12. The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record that an anti-platelet agent (aspirin, clopidogrel, dipyridamole or a combination), or an anti-coagulant is being taken (unless a contraindication or side-effects are recorded)	4	40-90%
STROKE 10. The percentage of patients with TIA or stroke who have had influenza immunisation in the preceding 1 September to 31 March	2	40-85%

## Hypertension

Indicator	Points	Payment stages
<b>Records</b>		
BP1. The practice can produce a register of patients with established hypertension	6	
<b>Ongoing management</b>		

BP4. The percentage of patients with hypertension in whom there is a record of the blood pressure in the preceding 9 months	16	40-90%
BP5. The percentage of patients with hypertension in whom the last blood pressure (measured in the preceding 9 months) is 150/90 or less	57	40-70%

## Diabetes mellitus

Indicator	Points	Payment stages
<b>Records</b>		
DM19. The practice can produce a register of all patients aged 17 years and over with diabetes mellitus, which specifies whether the patient has Type 1 or Type 2 diabetes	6	
<b>Ongoing management</b>		
DM2. The percentage of patients with diabetes whose notes record BMI in the preceding 15 months	3	40-90%
DM26. The percentage of patients with diabetes in whom the last IFCC-HbA1c is 59 mmol/mol (equivalent to HbA1c of 7.5% in DCCT values) or less (or equivalent test/reference range depending on local laboratory) in the preceding 15 months NICE menu ID: NM14	17	40-50%
DM27. The percentage of patients with diabetes in whom the last IFCC-HbA1c is 64 mmol/mol (equivalent to HbA1c of 8% in DCCT values) or less (or equivalent test/reference range depending on local laboratory) in the preceding 15 months	8	40-70%
DM28. The percentage of patients with diabetes in whom the last IFCC-HbA1c is 75 mmol/mol (equivalent to HbA1c of 9% in DCCT values) or less (or equivalent test/reference range depending on local laboratory) in the preceding 15 months	10	40-90%
DM21. The percentage of patients with diabetes who have a record of retinal screening in the preceding 15 months	5	40-90%
DM29. The percentage of patients with diabetes with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 15 months NICE menu ID: NM13	4	40-90%

DM10. The percentage of patients with diabetes with a record of neuropathy testing in the preceding 15 months	3	40-90%
DM30. The percentage of patients with diabetes in whom the last blood pressure is 150/90 or less NICE menu ID: NM01	8	40-71%
DM31. The percentage of patients with diabetes in whom the last blood pressure is 140/80 or less NICE menu ID: NM02	10	40-60%
DM13. The percentage of patients with diabetes who have a record of micro-albuminuria testing in the preceding 15 months (exception reporting for patients with proteinuria)	3	40-90%
DM22. The percentage of patients with diabetes who have a record of estimated glomerular filtration rate (eGFR) or serum creatinine testing in the preceding 15 months	3	40-90%
DM15. The percentage of patients with diabetes with a diagnosis of proteinuria or micro-albuminuria who are treated with ACE inhibitors (or A2 antagonists)	3	40-80%
DM17. The percentage of patients with diabetes whose last measured total cholesterol within the preceding 15 months is 5mmol/l or less	6	40-70%
DM18. The percentage of patients with diabetes who have had influenza immunisation in the preceding 1 September to 31 March	3	40-85%

### Chronic obstructive pulmonary disease (COPD)

Indicator	Points	Payment stages
<b>Records</b>		
COPD14. The practice can produce a register of patients with COPD	3	
<b>Initial diagnosis</b>		
COPD15. The percentage of all patients with COPD diagnosed after 1 April 2011 in whom the diagnosis has been confirmed by post bronchodilator spirometry	5	40-80%
<b>Ongoing management</b>		
COPD10. The percentage of patients with COPD with a record of FEV1 in the preceding 15 months	7	40-70%

COPD13. The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the MRC dyspnoea score in the preceding 15 months	9	50-90%
COPD8. The percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March	6	40-85%

## Epilepsy

Indicator	Points	Payment stages
<b>Records</b>		
EPILEPSY 5. The practice can produce a register of patients aged 18 years and over receiving drug treatment for epilepsy	1	
<b>Ongoing management</b>		
EPILEPSY 6. The percentage of patients aged 18 years and over on drug treatment for epilepsy who have a record of seizure frequency in the preceding 15 months	4	40-90%
EPILEPSY 8. The percentage of patients aged 18 years and over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the preceding 15 months	6	40-70%
EPILEPSY 9. The percentage of women under the age of 55 years who are taking antiepileptic drugs who have a record of information and counselling about contraception, conception and pregnancy in the preceding 15 months NICE menu ID: NM03	3	40-90%

## Hypothyroid

Indicator	Points	Payment stages
<b>Records</b>		
THYROID 1. The practice can produce a register of patients with hypothyroidism	1	
<b>Ongoing management</b>		
THYROID 2. The percentage of patients with hypothyroidism with thyroid function tests recorded in the preceding 15 months	6	40-90%

## Cancer

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

## Palliative care

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

## Mental health

Indicator	Points	Payment stages
<b>Records</b>		
MH8. The practice can produce a register of people with schizophrenia, bipolar affective disorder and other psychoses	4	
<b>Ongoing management</b>		
MH11. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months NICE menu ID: NM15	4	40-90%

MH12. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 15 months NICE menu ID: NM16	4	40-90%
MH13. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 15 months NICE menu ID: NM17	4	40-90%
MH14. The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol:hdl ratio in the preceding 15 months NICE menu ID: NM18	5	40-80%
MH15. The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose in the preceding 15 months NICE menu ID: NM19	5	40-80%
MH16. The percentage of patients (aged from 25 to 64 in England and Northern Ireland, from 20 to 60 in Scotland and from 20 to 64 in Wales) with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years NICE menu ID: NM20	5	40-80%
MH17. The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months NICE menu ID: NM21	1	40-90%
MH18. The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months NICE menu ID: NM22	2	40-90%
MH10. The percentage of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate	6	25-50%

## Asthma

Indicator	Points	Payment stages
Records		



ASTHMA 1. The practice can produce a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the preceding 12 months	4	
<b>Initial Management</b>		
ASTHMA 8. The percentage of patients aged 8 years and over diagnosed as having asthma from 1 April 2006 with measures of variability or reversibility	15	40-80%
<b>Ongoing management</b>		
ASTHMA 3. The percentage of patients with asthma between the ages of 14 and 19 years in whom there is a record of smoking status in the preceding 15 months	6	40-80%
ASTHMA 6. The percentage of patients with asthma who have had an asthma review in the preceding 15 months	20	40-70%

## Dementia

Indicator	Points	Payment stages
<b>Records</b>		
DEM1. The practice can produce a register of patients diagnosed with dementia	5	
<b>Ongoing management</b>		
DEM2. The percentage of patients diagnosed with dementia whose care has been reviewed in the preceding 15 months	15	25-60%
DEM3. The percentage of patients with a new diagnosis of dementia (from 1 April 2011) with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded 6 months before or after entering on to the register NICE menu ID: NM09	6	40-80%

## Depression

Indicator	Points	Payment stages
<b>Diagnosis and initial management</b>		
DEP1. The percentage of patients on the diabetes register and/or the CHD register for whom case finding for depression has been undertaken on one	6	40-90%

occasion during the preceding 15 months using two standard screening questions		
DEP4. In those patients with a new diagnosis of depression, recorded between the preceding 1 April to 31 March, the percentage of patients who have had an assessment of severity at the time of diagnosis using an assessment tool validated for use in primary care <i>NICE menu ID: NM10</i>	17	40-90%
DEP5. In those patients with a new diagnosis of depression and assessment of severity recorded between the preceding 1 April to 31 March, the percentage of patients who have had a further assessment of severity 4 - 12 weeks (inclusive) after the initial recording of the assessment of severity. Both assessments should be completed using an assessment tool validated for use in primary care <i>NICE menu ID: NM11</i>	8	40-80%

## Chronic kidney disease (CKD)

Indicator	Points	Payment stages
<b>Records</b>		
CKD1. The practice can produce a register of patients aged 18 years and over with CKD (US National Kidney Foundation: Stage 3 to 5 CKD)	6	
<b>Initial management</b>		
CKD2. The percentage of patients on the CKD register whose notes have a record of blood pressure in the preceding 15 months	6	40-90%
<b>Ongoing management</b>		
CKD3. The percentage of patients on the CKD register in whom the last blood pressure reading, measured in the preceding 15 months, is 140/85 or less	11	40-70%
CKD5. The percentage of patients on the CKD register with hypertension and proteinuria who are treated with an angiotensin converting enzyme inhibitor (ACE-I) or angiotensin receptor blocker (ARB) (unless a contraindication or side-effects are recorded)	9	40-80%
CKD6. The percentage of patients on the CKD register whose notes have a record of a urine albumin:creatinine ratio (or protein:creatinine ratio) test in the preceding 15 months	6	40-80%

## Atrial fibrillation

Indicator	Points	Payment stages
<b>Records</b>		
AF1. The practice can produce a register of patients with atrial fibrillation	5	
<b>Initial diagnosis</b>		
AF4. The percentage of patients with atrial fibrillation diagnosed after 1 April 2008 with ECG or specialist confirmed diagnosis	10	40-90%
<b>Ongoing management</b>		
AF3. The percentage of patients with atrial fibrillation who are currently treated with anti-coagulation drug therapy or an anti-platelet therapy	12	40-90%

## Obesity

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

## Learning disability

Indicator	Points	Payment stages
<b>Records</b>		
LD1. The practice can produce a register of patients aged 18 years and over with learning disabilities	4	
LD2. The percentage of patients on the learning disability register with Down's Syndrome aged 18 years and over who have a record of blood TSH in the preceding 15 months (excluding those who are on the thyroid disease register) NICE menu ID: NM04	3	40-70%

## Smoking

Indicator	Points	Payment stages
<b>On-going management</b>		
Smoking 3. The percentage of patients with any or any combination of the following conditions: CHD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 15 months	30	40-90%
Smoking 4. The percentage of patients with any or any combination of the following conditions: CHD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who smoke whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered within the preceding 15 months	30	40-90%

## Organisational domain

### Records and information

	Indicator	Points
<b>Records 3</b>	The practice has a system for transferring and acting on information about patients seen by other doctors out of hours	1
<b>Records 8</b>	There is a designated place for the recording of drug allergies and adverse reactions in the notes and these are clearly recorded	1
<b>Records 9</b>	For repeat medicines, an indication for the drug can be identified in the records (for drugs added to the repeat prescription with effect from 1 April 2004). Minimum Standard 80%	4
<b>Records 11</b>	The blood pressure of patients aged 45 years and over is recorded in the preceding 5 years for at least 65% of patients	10
<b>Records 13</b>	There is a system to alert the out of hours service or duty doctor to patients dying at home	2
<b>Records 15</b>	The practice has up to date clinical summaries in at least 60% of patient records	25
<b>Records 17</b>	The blood pressure of patients aged 45 years and over is recorded in the preceding 5 years for at least 80% of patients	5
<b>Records 18</b>	The practice has up to date clinical summaries in at least 80% of patient records	8
<b>Records 19</b>	80% of newly registered patients have had their notes summarised within 8 weeks of receipt by the practice	7
<b>Records 20</b>	The practice has up to date clinical summaries in at least 70% of patient records	12
<b>Records 23</b>	The percentage of patients aged 15 years and over whose notes record smoking status in the preceding 27 months (Payment stages 40–90%)	11

### Information for patients

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

## Education and training

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

## Practice management

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

<b>Management 2</b>	There are clearly defined arrangements for backing up computer data, back-up verification, safe storage of back-up tapes and authorisation for loading programmes where a computer is used	1
<b>Management 3</b>	The Hepatitis B status of all doctors and relevant practice-employed staff is recorded and immunisation recommended if required in accordance with national guidance	0.5
<b>Management 5</b>	The practice offers a range of appointment times to patients, which as a minimum should include morning and afternoon appointments 5 mornings and 4 afternoons per week, except where agreed with the PCO	3
<b>Management 7</b>	The practice has systems in place to ensure regular and appropriate inspection, calibration, maintenance and replacement of equipment including:  A defined responsible person Clear recording Systematic pre-planned schedules Reporting of faults	3
<b>Management 9</b>	The practice has a protocol for the identification of carers and a mechanism for the referral of carers for social services assessment	3
<b>Management 10</b>	There is a written procedures manual that includes staff employment policies including equal opportunities, bullying and harassment and sickness absence (including illegal drugs, alcohol and stress), to which staff have access	2

## Medicines management

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

<b>Medicines 8</b>	The number of hours from requesting a prescription to availability for collection by the patient is 48 hours or less (excluding weekends and bank/local holidays)	6
<b>Medicines 10</b>	The practice meets the PCO prescribing adviser at least annually, has agreed up to three actions related to prescribing and subsequently provided evidence of change	4
<b>Medicines 11</b>	A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed four or more repeat medicines Standard 80%	7
<b>Medicines 12</b>	A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed repeat medicines Standard 80%	8

### Quality and Productivity

	<b>Indicator</b>	<b>Points</b>
<b>QP1</b>	The practice conducts an internal review of their prescribing to assess whether it is clinically appropriate and cost effective, agrees with the PCO three areas for improvement and produces a draft plan for each area no later than 30 June 2011	6
<b>QP2</b>	The practice participates in an external peer review of prescribing with a group of practices and agrees plans for three prescribing areas for improvement firstly with the group and then with the PCO no later than 30 September 2011	7
<b>QP3</b>	The percentage of prescriptions complying with the agreed plan for the first improvement area as a percentage of all prescriptions in that improvement area during the period 1 January 2012 to 31 March 2012 .  (Payment stages to be determined locally according to the method set out in the indicator guidance below with 20 percentage points between upper and lower thresholds)	5
<b>QP4</b>	The percentage of prescriptions complying with the agreed plan for the second improvement area as a percentage of all prescriptions in that improvement area during the period 1 January 2012 to 31 March 2012 .  (Payment stages to be determined locally according to the method set out in the indicator guidance below with 20 percentage points between upper and lower thresholds)	5



<b>QP5</b>	The percentage of prescriptions complying with the agreed plan for the third improvement area as a percentage of all prescriptions in that improvement area during the period 1 January 2012 to 31 March 2012 .  (Payment stages to be determined locally according to the method set out in the indicator guidance below with 20 percentage points between upper and lower thresholds)	5
<b>QP6</b>	The practice meets internally to review the data on secondary care outpatient referrals provided by the PCO	5
<b>QP7</b>	The practice participates in an external peer review with a group of practices to compare its secondary care outpatient referral data either with practices in the group of practices or with practices in the PCO area and proposes areas for commissioning or service design improvements to the PCO	5
<b>QP8</b>	The practice engages with the development of and follows three agreed care pathways for improving the management of patients in the primary care setting (unless in individual cases they justify clinical reasons for not doing this) to avoid inappropriate outpatient referrals and produces a report of the action taken to the PCO no later than 31 March 2012	11
<b>QP9</b>	The practice meets internally to review the data on emergency admissions provided by the PCO	5
<b>QP10</b>	The practice participates in an external peer review with a group of practices to compare its data on emergency admissions either with practices in the group of practices or practices in the PCO area and proposes areas for commissioning or service design improvements to the PCO	15
<b>QP11</b>	The practice engages with the development of and follows three agreed care pathways (unless in individual cases they justify clinical reasons for not doing this) in the management and treatment of patients in aiming to avoid emergency admissions and produces a report of the action taken to the PCO no later than 31 March 2012	27.5

## Patient experience domain

Indicator	Points
<p>PE 1 Length of consultations</p> <p>The length of routine booked appointments with the doctors in the practice is not less than 10 minutes (If the practice routinely sees extras during booked surgeries, then the average booked consultation length should allow for the average number of extras seen in a surgery session. If the extras are seen at the end, then it is not necessary to make this adjustment). For practices with only an open surgery system, the average face to face time spent by the GP with the patient is at least 8 minutes. Practices that routinely operate a mixed economy of booked and open surgeries should report on both criteria</p>	33

## Additional services domain

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

### Cervical screening (CS)

	Indicator	Points
CS1	The percentage of patients (aged from 25 to 64 in England and Northern Ireland, from 20 to 60 in Scotland and from 20 to 64 in Wales) whose notes record that a cervical screening test has been performed in the preceding 5 years (Payment stages 40–80%)	11
CS5	The practice has a system for informing all women of the results of cervical smears	2
CS6	The practice has a policy for auditing its cervical screening service, and performs an audit of inadequate cervical smears in relation to individual smear-takers at least every 2 years	2
CS7	The practice has a protocol that is in line with national guidance and practice for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate smear rates	7

### Child health surveillance (CHS)

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

### Maternity services (MAT)

	Indicator	Points
MAT1	Ante-natal care and screening are offered according to current local guidelines	6

## Contraception (SH)

	Indicator	Points
SH1	The practice can produce a register of women who have been prescribed any method of contraception at least once in the last year, or other appropriate interval e.g. last 5 years for an IUS	4
SH2	The percentage of women prescribed an oral or patch contraceptive method who have also received information from the practice about long acting reversible methods of contraception in the preceding 15 months (Payment stages 40–90%)	3
SH3	The percentage of women prescribed emergency hormonal contraception at least once in the year by the practice who have received information from the practice about long acting reversible methods of contraception at the time of, or within one month of, the prescription (Payment stages 40–90%)	3

## Section 2: Clinical Domain

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

Indicator	Points	Payment stages
<b>Records</b>		
CHD1. The practice can produce a register of patients with coronary heart disease	4	
<b>Diagnosis and initial management</b>		
CHD13. For patients with newly diagnosed angina (diagnosed after 1 April 2011), the percentage who are referred for specialist assessment NICE menu ID: NM08	7	40–90%
<b>Ongoing management</b>		
CHD6. The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 or less	17	40-71%
CHD8. The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 15 months) is 5mmol/l or less	17	40-70%
CHD9. The percentage of patients with coronary heart disease with a record in the preceding 15 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken (unless a contraindication or side-effects are recorded)	7	40-90%
CHD10. The percentage of patients with coronary heart disease who are currently treated with a beta-blocker (unless a contraindication or side-effects are recorded)	7	40-60%
CHD14. The percentage of patients with a history of myocardial infarction (from 1 April 2011) currently treated with an ACE inhibitor (or ARB if ACE intolerant), aspirin or an alternative anti-platelet therapy, beta-blocker and statin (unless a contraindication or side-effects are recorded) NICE menu ID: NM07	10	40-80%
CHD12. The percentage of patients with coronary heart disease who have a record of influenza immunisation in the preceding 1 September to 31 March	7	40-90%

## **CHD - Rationale for inclusion of indicator set**

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

### **CHD Indicator 1**

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

#### **CHD 1.1 Rationale**

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

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

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

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

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

### **CHD Indicator 13 (NICE menu NM08)**

For patients with newly diagnosed angina (diagnosed after 1 April 2011), the percentage who are referred for specialist assessment.

#### **CHD Indicator 13.1 Rationale**

Angina due to coronary artery disease (CAD) can be diagnosed on clinical grounds but many patients require referral for specialist assessment to confirm or exclude the diagnosis. Patients may then undergo functional or anatomical testing. Functional testing includes myocardial perfusion scanning, anatomical testing includes coronary angiography.

It has been common clinical practice to use exercise testing (also termed exercise electrocardiogram (ECG), stress ECG or exercise tolerance test) to help establish a diagnosis of suspected angina. However, the NICE clinical guideline on chest pain of recent onset<sup>(9)</sup> explicitly states that exercise ECG should not be used to diagnose or

---

<sup>(9)</sup> NICE clinical guideline 95 (2010). Chest pain of recent onset. [www.nice.org.uk/guidance/CG95](http://www.nice.org.uk/guidance/CG95)

exclude stable angina in people without known coronary artery disease (CAD). This represents a significant shift in current practice.

Recommendation 1.3.1.1 of the NICE guideline states that a diagnosis of stable angina should be based on one of the following:

- clinical assessment alone **or**
- clinical assessment plus diagnostic testing (that is, anatomical testing for obstructive coronary artery disease [CAD] and/or functional testing for myocardial ischaemia)

In order to make a diagnosis on clinical assessment alone, clinicians should take a detailed clinical history and perform a physical examination (see recommendations 1.3.2.1 and 1.3.2.2). Anginal pain is identified as:

- a constricting discomfort in the front of the chest, or in the neck, shoulders, jaw, or arms
- which is precipitated by physical exertion
- and which is relieved by rest or GTN (glyceryl trinitrate) within about five minutes

The NICE guideline states that when all three of the features described above are identified, this is defined as ‘typical’ angina. When only two are present this is defined as ‘atypical’ angina and when only one or none are present then this is defined as ‘non-anginal’ chest pain.

In addition to the typicality of the reported chest pain, a clinical assessment needs to take account of the patient’s age, sex and presence of additional risk factors (diabetes, smoking and hyperlipidaemia). The clinician can then use an estimate of the prevalence of CAD in the population (table 1) to inform their clinical decision as to the likelihood of an individual patient having angina due to CAD and whether or not they need to be referred for further specialist assessment.

**Table 1: Percentage of people estimated to have CAD according to typicality of symptoms, age, sex and risk factors**

	Non-anginal chest pain				Atypical angina				Typical angina			
	Men		Women		Men		Women		Men		Women	
Age (yrs)	Lo	Hi	Lo	Hi	Lo	Hi	Lo	Hi	Lo	Hi	Lo	Hi
35	3	35	1	19	8	59	2	39	30	88	10	78
45	9	47	2	22	21	70	5	43	51	92	20	79
55	23	59	4	25	45	79	10	47	80	95	38	82
65	49	69	9	29	71	86	20	51	93	97	56	84
For men older than 70 with atypical or typical symptoms, assume an estimate > 90%. For women older than 70 assume an estimate of 61-90% EXCEPT women at high risk and with typical symptoms where a risk of > 90% should be assumed.												
Values are percentage of people at each mid-decade age with significant CAD. Hi = High risk = diabetes, smoking and hyperlipidaemia (total cholesterol > 6.47 mmol/litre)												

Lo = Low risk = none of the above three risk factors

The shaded area represents people with symptoms of non-anginal chest pain, who would not be investigated for stable angina routinely.

Note:

These results are likely to overestimate CAD in primary care populations.

If there are resting ECG ST-T changes or Q waves, the likelihood of CAD is higher in each cell of the table.

In those people who have features of typical angina and their population estimated likelihood of CAD is greater than 90 per cent clinical assessment alone is appropriate to make a diagnosis of stable angina. These patients should be managed as having angina. For example, men aged over 65 years with typical angina symptoms do not need to be referred to confirm the diagnosis. Where the diagnosis is made by clinical assessment alone, then an explanation of how the diagnosis of angina has been made should be included in the patient's notes.

In people with suspected angina where there is uncertainty regarding the diagnosis (people with a population estimated likelihood of CAD of 10 - 90 per cent), clinical assessment and referral for specialist assessment (diagnostic testing) is required.

In people with a population estimated likelihood of CAD of less than ten per cent, causes of chest pain other than angina should be considered first. These patients are not included in the target population for this indicator unless they are subsequently diagnosed with angina.

Further information

SIGN clinical guideline 96 (2007). Management of stable angina.  
[www.sign.ac.uk/guidelines/fulltext/96](http://www.sign.ac.uk/guidelines/fulltext/96)

## CHD 13.2 Reporting and verification

The practice reports the percentage of patients diagnosed with angina from 1 April 2011 who have been referred for specialist assessment within 12 months of being added to the register. The practice should also report patients who have been referred up to three months before being added to the register.

Where a patient has been diagnosed on clinical assessment alone, then an explanation should be included in the patient notes as to how the diagnosis has been made. These patients will need to be exception reported against this indicator as referral for specialist assessment only applies to those patients in whom it was not possible to make a diagnosis of angina on clinical grounds alone.

## CHD Indicator 6

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



## CHD 6.1 Rationale

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

Further Information

British Hypertension Society (2006). [www.bhsoc.org/NICE\\_BHS\\_Guidelines.stm](http://www.bhsoc.org/NICE_BHS_Guidelines.stm)

A major overview of randomised trials showed that a reduction of 5 - 6 mmHg in blood pressure sustained over five years reduces coronary events by 20 - 25 per cent in patients with CHD<sup>(10)</sup>.

## CHD 6.2 Reporting and verification

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

## CHD Indicator 8

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

## CHD 8.1 Rationale

A number of Randomised Controlled Trials (RCTs) of statin therapy in the secondary prevention of CHD have shown a reduction in relative risk of cardiac events irrespective of the starting level of cholesterol<sup>(11)</sup>. Recent trials have found greater relative benefit with more potent cholesterol lowering regimes. It is likely that National Guidelines relating to statin therapy in patients with CHD will change to recommend statin therapy for all patients with CHD irrespective of their starting level of total cholesterol.

Joint British Societies' (JBS) recommendations on the prevention of CHD in Clinical Practice (2005)<sup>(12)</sup> maintains an "audit standard" for total cholesterol of, 5.0 mmol/l and recommended therapeutic treatment in patients who have cholesterol of greater than 5mmol/l.

NICE clinical guideline 67<sup>(13)</sup> on lipid modification recommends that an 'audit' level of total cholesterol of 5mmol/l should be used to assess progress in populations or groups of people with cardiovascular disease.

The guidance here is given in terms of total cholesterol.

---

<sup>(10)</sup> Collins et al. *Lancet* 1990; 335: 827-38

<sup>(11)</sup> [www.sign.ac.uk/guidelines/fulltext/93-97/index.html](http://www.sign.ac.uk/guidelines/fulltext/93-97/index.html)

<sup>(12)</sup> Joint British Societies' JBS (2005). <http://www.bcs.com/download/651/JBS2final.pdf>

<sup>(13)</sup> NICE clinical guideline 67 (2010). Recommendation 1.4.25.

<http://www.nice.org.uk/nicemedia/live/11982/40689/40689.pdf>

## CHD 8.2 Reporting and verification

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

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

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

## CHD Indicator 9

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

### CHD 9.1 Rationale

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

Further information

SIGN clinical guideline 96 and 97. Grade A Recommendation.

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

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

Since the original QOF guidance in 2003, NICE have released guidance on the appropriate use of clopidogrel:

Clopidogrel alone (within its licensed indications) is recommended for people who are intolerant of low-dose aspirin and either have experienced an occlusive vascular event or have symptomatic peripheral artery disease.

NICE define aspirin intolerance as either of the following: proven hypersensitivity to aspirin-containing medicines or history of severe dyspepsia induced by low-dose aspirin.

- Clopidogrel, in combination with low-dose aspirin, is recommended for use in the management of non-ST-segment-elevation acute coronary syndrome (ACS) in people who are at moderate to high risk of myocardial infarction (MI) or death. NICE recommend that treatment with clopidogrel in

combination with low-dose aspirin should be continued for up to 12 months after the most recent acute episode of non-ST-segment-elevation ACS. Thereafter, standard care, including treatment with low-dose aspirin alone, is recommended. Moderate to high risk of MI or death in people presenting with non-ST-segment-elevation ACS can be determined by clinical signs and symptoms, accompanied by one or both of the following:

1. The results of clinical investigations, such as new ECG changes (other than persistent ST-segment-elevation), indicating ongoing myocardial ischaemia, particularly dynamic or unstable patterns.
2. The presence of raised blood levels of markers of cardiac cell damage such as troponin.

Further information

NICE technology appraisal 80 (2004). Clopidogrel in the treatment of non-ST-segment-elevation acute coronary syndrome. <http://www.nice.org.uk/Guidance/TA80>

NICE technology appraisal 90 (2005). Clopidogrel and dipyridamole for the prevention of atherosclerotic events. <http://www.nice.org.uk/Guidance/TA90>

## **CHD 9.2 Reporting and verification**

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

## **CHD Indicator 10**

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

### **CHD 10.1 Rationale**

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

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

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

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

### **CHD 10.2 Reporting and verification**

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

## CHD Indicator 14 (NICE menu NM07)

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

### CHD 14.1 Rationale

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

- ACE (angiotensin-converting enzyme) inhibitor (or ARB if ACE intolerant)
- aspirin
- beta-blocker
- statin

There is also health economic evidence to suggest that these drug interventions are cost-effective.

#### ACE inhibitor

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

Long term treatment with an ACE inhibitor in patients with signs of heart failure and/or left ventricular systolic dysfunction who have recently experienced an MI was associated with a substantial reduction in all-cause mortality, recurrent MI and re-admission for heart failure.

Where patients are intolerant of an ACE inhibitor (for example because of a cough or allergy) it is recommended that an ARB (angiotensin receptor blocker) is substituted.

#### Aspirin and alternative antiplatelet therapy

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

#### Warfarin

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

#### Beta-blocker

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

## Statins

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

### Further information

NICE clinical guideline 48 (2007). MI secondary prevention in primary and secondary care for patients following a myocardial infarction. [www.nice.org.uk/guidance/CG48](http://www.nice.org.uk/guidance/CG48)

NICE technology appraisal 94 (2006). Statins for the prevention of cardiovascular events in patients at increased risk of developing CVD or those with established CVD. [www.nice.org.uk/guidance/TA94](http://www.nice.org.uk/guidance/TA94)

NICE clinical guideline 67 (2007). Lipid modification. [www.nice.org.uk/guidance/CG67](http://www.nice.org.uk/guidance/CG67)

## CHD 14.2 Reporting and verification

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

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

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

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

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

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

A patient will count towards the target (included in the denominator but not the numerator) if they are:

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

The practice reports the percentage of patients who have had a myocardial infarction (from 1 April 2011) currently treated with an ACE inhibitor (or ARB if ACE

intolerant), aspirin or an alternative anti-platelet or anticoagulant therapy, beta-blocker and statin (unless a contraindication or side-effects are recorded).

## **CHD Indicator 12**

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

### **CHD 12.1 Rationale**

This is a current recommendation from the Scottish Government and the Joint Committee on Vaccination and Immunisation (JCVI).

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

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

## Cardiovascular disease – primary prevention

Indicator	Points	Payment stages
<b>Initial diagnosis</b>		
PP1. In those patients with a new diagnosis of hypertension (excluding those with pre-existing CHD, diabetes, stroke and/or TIA) recorded between the preceding 1 April to 31 March: the percentage of patients aged 30 to 74 years who have had a face to face cardiovascular risk assessment at the outset of diagnosis (within three months of the initial diagnosis) using an agreed risk assessment tool. NICE menu ID: NM06	8	40-70%
<b>Ongoing management</b>		
PP2. The percentage of people diagnosed with hypertension (diagnosed after 1 April 2009) who are given lifestyle advice in the preceding 15 months for: increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet.	5	40-70%

### Cardiovascular disease – primary prevention - rationale for inclusion of indicator set

Cardiovascular Disease (CVD) is the most common cause of death in the UK, and importantly for patients, the major cause of premature death (before 65 years). Moreover, of greater significance for the NHS, CVD is now the commonest cause of disability (through stroke and heart failure particularly) and hospital admission. This results in CVD being the major cost driver for health utilisation and remains the end point disease for many other chronic disorders, especially diabetes and renal disease.

Primary prevention (PP) works and evidence based interventions can dramatically reduce risk – in North Karelia which had the highest CVD rates in Europe 25 years ago, CVD mortality has reduced by 50 per cent through rigid implementation of public health and individual patient interventions. Analysis of CHD trends in Ireland found that over a 15 year period, primary prevention achieved a two-fold larger reduction in CHD deaths than secondary prevention, with 68 per cent of the 2530 fewer deaths attributable to CHD (using the IMPACT CHD mortality model) having occurred in people without recognised CHD compared to 32 per cent in CHD patients<sup>(14)</sup>.

<sup>(14)</sup> Kabir Z. , Bennett K. , Shelley E. , Unal B. , Critchley J. , Capwell S. Comparing primary prevention with secondary prevention to explain decreasing Coronary Heart Disease death rates in Ireland, 1985-2000. BMC Public Health 2007, 7:17.

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

In those patients with a new diagnosis of hypertension (excluding those with pre-existing CHD, diabetes, stroke and/or TIA) recorded between the preceding 1 April to 31 March: the percentage of patients aged 30 to 74 years who have had a face to face cardiovascular risk assessment at the outset of diagnosis (within three months of the initial diagnosis) using an agreed risk assessment tool.

### Primary prevention 1.1 Rationale

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

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

- Framingham
- Joint British Society 2 (JBS2)
- QRISK
- Assessing cardiovascular risk using SIGN guidelines to assign preventive treatment (ASSIGN - Scotland only)

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

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

Framingham<sup>(15)</sup> and JBS<sup>(16)</sup> are based on the American Framingham equations which are of limited use in the UK as they were developed in an historic American population. The Framingham equations overestimate risk by up to 50 per cent in contemporary northern European populations, particularly in people living in more affluent areas. They underestimate risk in higher risk populations, such as people who are the most socially deprived. Framingham makes no allowance for a family history of premature CHD and does not take account of ethnicity, but does have a full dataset.

The newer risk scores, QRISK and ASSIGN, have the advantage of including other variables, such as measures of social deprivation, ethnicity and family history.

---

<sup>(15)</sup> Anderson KM, Odell, PM, Wilson PW et al. (1991) CVD risk profiles. American Heart Journal 121: 293-8. Risk profile only. [www.framinghamheartstudy.org/risk/coronary.html](http://www.framinghamheartstudy.org/risk/coronary.html)

<sup>(16)</sup> British Cardiac Society. British Hypertension Society. Diabetes UK. HEART UK. Primary Care Cardiovascular Society. Stroke Association (2005). JBS guidelines on prevention of CVD in clinical practice. Heart, 91: 1.52.



QRISK uses data from UK general practice databases, whereas ASSIGN was developed using a Scottish cohort and has not been validated in a non-Scottish population.

### Framingham and JBS2

The variables required for the estimation of risk using the Framingham risk assessment tool are age, sex, systolic blood pressure (mean of two previous systolic readings), total cholesterol, high density lipoprotein cholesterol, smoking status and presence of left ventricular hypertrophy. JBS2 utilises the Framingham variables with the exception of the presence of left ventricular hypertrophy<sup>(17)</sup>.

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

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

### QRISK

The QRISK CVD risk calculator was developed by doctors and academics working in the NHS and is based on routinely collected data from general practitioners (GPs) across the country. The current version of QRISK is QRISK2<sup>(18)</sup> (see [www.qrisk.org](http://www.qrisk.org)). QRISK2 utilises the following variables to calculate CVD risk: self assigned ethnicity, age, sex, smoking status, systolic blood pressure, total cholesterol, high density lipoprotein cholesterol, body mass index, family history of CHD in first degree relative under 60 years, Townsend deprivation score, treated hypertension, type 2 diabetes, renal disease, atrial fibrillation, and rheumatoid arthritis.

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

### ASSIGN

The ASSIGN cardiovascular risk score<sup>(19)</sup> was developed as part of the SIGN 97 process to reduce the deprivation-related underestimation of CVD risk inherent in previous Framingham-based risk scores for Scottish populations, and continues to be developed<sup>(20)</sup>. It is available via the Internet to practices in Scotland and, like QRISK calculates deprivation-related risk due to postcode. ASSIGN utilises the following variables to calculate CVD risk: age, sex, Scottish Index of Multiple Deprivation

<sup>(17)</sup> NICE clinical guideline 67 (2008). Lipid modification: cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease. [www.nice.org.uk/guidance/CG67](http://www.nice.org.uk/guidance/CG67)

<sup>(18)</sup> Hippisley-Cox J, Coupland C, Vinogradova Y et al. (2008) Predicting cardiovascular risk in England and Wales: prospective derivation and validation of QRISK2. *BMJ* 336: 1475–82

<sup>(19)</sup> ASSIGN cardiovascular risk score. [www.assign-score.com](http://www.assign-score.com)

<sup>(20)</sup> SIGN clinical guideline 97 (2007). Risk estimation and the prevention of CVD. [www.sign.ac.uk/guidelines/fulltext/97](http://www.sign.ac.uk/guidelines/fulltext/97)

(SIMD), family history of CHD and/or stroke, diabetes, smoking status, systolic blood pressure, total cholesterol and high density lipoprotein cholesterol. Scottish practices should use the ASSIGN risk score or the Framingham 1991 10-year risk equations for the purposes of this indicator.

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

#### Primary prevention 1.2 Reporting and verification

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

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

#### Primary prevention (PP) Indicator 2

The percentage of people diagnosed with hypertension (diagnosed after 1 April 2009) who are given lifestyle advice in the preceding 15 months for: increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet.

#### Primary prevention 2.1 Rationale

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

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

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

This advice should be reiterated on an annual basis.

#### Further information

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

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

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

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

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

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

Plan for Action on Alcohol Problems Update Scottish Government 2008 <http://www.scotland.gov.uk/Publications/2007/02/19150222/12>

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

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

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

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

#### Primary prevention (PP) 2.2 Reporting and verification

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

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

## Heart failure

Indicator	Points	Payment stages
<b>Records</b>		
HF1. The practice can produce a register of patients with heart failure	4	
<b>Initial diagnosis</b>		
HF2. The percentage of patients with a diagnosis of heart failure (diagnosed after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment	6	40-90%
<b>Ongoing management</b>		
HF3. The percentage of patients with a current diagnosis of heart failure due to Left Ventricular Dysfunction (LVD) who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker (ARB), who can tolerate therapy and for whom there is no contraindication	10	40-80%
HF4. The percentage of patients with a current diagnosis of heart failure due to LVD who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker (ARB), who are additionally treated with a beta-blocker licensed for heart failure, or recorded as intolerant to or having a contraindication to beta-blockers.	9	40-60%

### Heart failure - rationale for inclusion of indicator set

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

### Heart failure (HF) indicator 1

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

#### Heart failure 1.1 Rationale

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

#### Heart failure 1.2 Reporting and verification

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

## Heart failure (HF) Indicator 2

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

### Heart failure 2.1 Rationale

From April 2006, this indicator requires that all patients with suspected HF should be investigated<sup>(21)</sup> and this is expected to involve, as a minimum, specialist investigation (such as echocardiography or natriuretic peptide assay) and often specialist opinion. Specialists may include GPs identified by their PCO as having a special clinical interest in HF. Many HF patients will be diagnosed following specialist referral or during hospital admission and some will also have their diagnosis confirmed by tests such as cardiac scintigraphy or angiography rather than echocardiography. Current guidance<sup>(22)</sup> requires either echocardiography or specialist assessment for all patients with suspected HF, regardless of presumed aetiology.

Further information

NICE clinical guideline 108 (2010). Management of chronic heart failure in adults in primary and secondary care. <http://guidance.nice.org.uk/CG108>

SIGN clinical guideline 95 (2007). Management of chronic heart failure. <http://www.sign.ac.uk/guidelines/fulltext/95/index.html>

### Heart failure 2.2 Reporting and verification

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

## Heart failure (HF) indicator 3

The percentage of patients with a current diagnosis of heart failure due to Left Ventricular Dysfunction (LVD) who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker (ARB), who can tolerate therapy and for whom there is no contraindication.

### Heart failure 3.1 Rationale

The evidence base for treating patients with LVD HF with ARBs is strong, however, this should only be after first attempting to initiate ACE inhibitors<sup>(23)</sup> (ACE-I).

It should also be noted that it is possible to have a diagnosis of LVD 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 inhibitors delay the onset of symptomatic HF, reduce cardiovascular events and improve long term survival.

---

<sup>(21)</sup> Senni et al. *J Am Coll Cardiol*. 1999; 33(1): 164 – 70; NICE *clinical guideline 5*. NICE. 2003

<sup>(22)</sup> Remme et al. *Eur Heart J* 2001; 22: 1527-60

<sup>(23)</sup> Pfeffer et al. *Lancet* 2003; 362: 759-766

This indicator only concerns patients with HF and thus excludes this other group of patients who should nevertheless be considered for treatment with ACE-I.

Further information

[www.clinicalevidence.com/cweb/conditions/cvd/0204/0204\\_I13.jsp](http://www.clinicalevidence.com/cweb/conditions/cvd/0204/0204_I13.jsp)

SIGN clinical guideline 95 (2007). Management of chronic heart failure. <http://www.sign.ac.uk/guidelines/fulltext/95/index.html>

## Heart failure 3.2 Reporting and verification

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

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

## Heart failure (HF) indicator 4

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

## Heart failure 4.1 Rationale

The evidence base for treating HF due to LVD with beta-blockers<sup>(24)</sup> <sup>(25)</sup> is at least as strong as the evidence base guiding the HF3 indicator on ACE-I (Level 1a), with a 34 per cent reduction in major endpoints of beta-blockers on top of ACE inhibitors compared to placebo, and is a standard recommendation in all HF guidelines including NICE. The belief that beta-blockers are contra-indicated in HF was disproved, at least for the licensed beta-blockers, in the late 1990s and in some countries (especially Scandinavia) beta-blockers have never been contraindicated in HF. Furthermore, there is no data to suggest excess risk in the elderly (SENIORS with nebivolol only randomised people over 75 years with significant benefits and no safety signal) and there are no contraindications for use in people with COPD.

However, this strategy is more difficult in clinical practice than initiating ACE (more contraindications, less tolerated, with a need for slower but more dose titration steps. Furthermore, there are negative trials of beta-blockers in HF<sup>(26)</sup> and concerns over the effectiveness of atenolol in reducing vascular risk generally. Therefore the beta-blocker used should be one licensed for HF, which is also in line with NICE

---

<sup>(24)</sup> Deedwania PC, Giles TD, Klibaner M, Ghali JK, Herlitz J, Hildebrandt P, Kjekshus J, Spinar J, Vitovec J, Stanbrook H, Wikstrand J; MERIT-HF Study Group. Efficacy, safety and tolerability of metoprolol CR/XL in patients with diabetes and chronic heart failure: experiences from MERIT-HF. *Am Heart J.* 2005; 49 (1):159-67.

<sup>(25)</sup> CIBIS-II Investigators and Committees. The Cardiac Insufficiency Bisoprolol Study II. *Lancet* 1999; 353: 9-13.

<sup>(26)</sup> Anderson JL, Krause-Steinrauf H, Goldman S, Clemson BS, Domanski MJ, Hager WD, Murray DR, Mann DL, Massie BM, McNamara DM, Oren R, Rogers WJ; Beta-Blocker Evaluation of Survival Trial (BEST) Investigators. Failure of benefit and early hazard of bucindolol for Class IV heart failure. *J Card Fail.* 2003; 9 (4): 266-77

recommendations. The only such agents in the UK are carvedilol, bisoprolol and nebivolol.

Practices should be aware that patients already prescribed a beta-blocker prior to diagnosis of HF due to LVD should not have their drug therapy changed to meet the criteria of this indicator. Those patients already prescribed a beta-blocker will be excluded from the achievement calculator.

However, despite the evidence above, initiating beta-blockers in HF, or switching from one not licensed for HF, is more difficult because of the need to titrate from low doses and small increments over repeated visits. Patients also often suffer a temporary deterioration in symptoms with beta-blocker initiation which needs monitoring. The British National Formulary (BNF) states that beta-blockers bisoprolol and carvedilol are of value in any grade of stable HF and left-ventricular systolic dysfunction; nebivolol is licensed for stable mild to moderate HF. Beta-blocker treatment should be started by those experienced in the management of HF, at a very low dose and titrated very slowly over a period of weeks or months. Symptoms may deteriorate initially, calling for adjustment of concomitant therapy<sup>(27)</sup>.

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

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

---

<sup>(27)</sup> <http://www.bnf.org/bnf/bnf/current/119651.htm> (password protected site)

## Stroke and Transient Ischaemic Attack (TIA)

Indicator	Points	Payment stages
<b>Records</b>		
STROKE 1. The practice can produce a register of patients with stroke or TIA	2	
STROKE 13. The percentage of new patients with a stroke or TIA who have been referred for further investigation	2	40-80%
<b>Ongoing management</b>		
STROKE 6. The percentage of patients with a history of TIA or stroke in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 or less	5	40-71%
STROKE 7. The percentage of patients with TIA or stroke who have a record of total cholesterol in the preceding 15 months	2	40-90%
STROKE 8. The percentage of patients with TIA or stroke whose last measured total cholesterol (measured in the preceding 15 months) is 5mmol/l or less	5	40-60%
STROKE 12. The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record that an anti-platelet agent (aspirin, clopidogrel, dipyridamole or a combination), or an anti-coagulant is being taken (unless a contraindication or side-effects are recorded)	4	40-90%
STROKE 10. The percentage of patients with TIA or stroke who have had influenza immunisation in the preceding 1 September to 31 March	2	40-85%

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

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

### Stroke indicator 1

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

### Stroke 1.1 Rationale

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



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

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

## **Stroke 1.2 Reporting and verification**

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

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

## **Stroke indicator 13**

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

## **Stroke 13.1 Rationale**

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

The National Audit Office (NAO) Report <sup>(28)</sup> highlights that UK national guidelines recommend that all patients with suspected TIA should be assessed and investigated within seven days, but notes that only a third of people with TIA are seen in a clinic. The UK Guideline and the NAO concern reflect the evidence that there is a high early risk of stroke following TIA, and that there is insufficient recognition of the serious nature of this diagnosis.

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

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

---

<sup>(28)</sup> National Audit Office report. The Stationary Office (2005). Reducing brain damage: faster access to better stroke care. [http://www.nao.org.uk/publications/0506/reducing\\_brain\\_damage.aspx](http://www.nao.org.uk/publications/0506/reducing_brain_damage.aspx)

## Stroke 13.2 Reporting and verification

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

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

1. inspection of the output from a computer search that has been used to provide information on this indicator
2. inspection of a sample of records of patients with stroke or TIA diagnosed after 1 April 2008 to look at the proportion referred for further investigation
3. inspection of a sample of records of patients for whom a record of investigations such as CT or MRI scan is claimed, to see if there is evidence of this in the medical records.

## Stroke indicator 6

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

### Stroke 6.1 Rationale

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

In one major overview, a long term difference of 5 - 6 mmHg in usual diastolic blood pressure (DBP) is associated with approximately 35 - 40 per cent less stroke over five years<sup>(29)</sup>. The PROGRESS trial demonstrated that blood pressure lowering reduces stroke risk in people with prior stroke or TIA<sup>(30)</sup>.

Further information

RCP Stroke Guideline 2004. Grade A Recommendation.  
[http://www.rcplondon.ac.uk/pubs/books/stroke/stroke\\_guidelines\\_2ed.pdf](http://www.rcplondon.ac.uk/pubs/books/stroke/stroke_guidelines_2ed.pdf)

### Stroke 6.2 Reporting and verification

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

---

<sup>(29)</sup> Collins et al. *Lancet* 1990; 335: 827-38

<sup>(30)</sup> PROGRESS Collaborative Group, *Lancet* 2001; 358:1033-41

## Stroke indicator 7

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

### Stroke 7.1 Rationale

The Heart Protection Study demonstrated that all cause mortality, vascular and stroke risk was significantly reduced by treating people at high risk of vascular disease with a statin <sup>(31)</sup>. Subsequent sub-group analyses demonstrated that in patients with prior stroke or TIA, statin therapy reduced risk of subsequent vascular events <sup>(32)</sup>. An economic analysis of this trial concluded that it was highly cost-effective to treat such patients <sup>(33)</sup>.

### Stroke 7.2 Reporting and verification

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

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

## Stroke indicator 8

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

### Stroke 8.1 Rationale

See Stroke 7.1.

### Stroke 8.2 Reporting and verification

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

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

## Stroke indicator 12

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

---

<sup>(31)</sup> Heart Protection Study Collaborative Group, *Lancet* 2002; 360:7-22

<sup>(32)</sup> Heart Protection Study Collaborative Group, *Lancet* 2004; 363:757-767

<sup>(33)</sup> Heart Protection Study Collaborative Group, *Lancet* 2005; 365:1779-85

## Stroke 12.1 Rationale

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

Further information

SIGN clinical guideline 108 (2008). Management of patients with stroke or TIA. Assessment, investigation, immediate management and secondary prevention. Grade A Recommendation. <http://www.sign.ac.uk/guidelines/fulltext/108/index.html>

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

RCP Stroke Guideline. Grade A Recommendation. <http://bookshop.rcplondon.ac.uk/details.aspx?e=250>

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

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

## Stroke 12.2 Reporting and verification

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

## Stroke indicator 10

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

## Stroke 10.1 Rationale

While there have been no randomised controlled trials (RCTs) looking at the impact of flu vaccination specifically in people with a history of stroke or TIA, there is evidence from observation studies that flu vaccination reduces risk of stroke<sup>(34)</sup>.

---

<sup>(34)</sup> Lavalley et al. *Stroke* 2002; 33: 513-518; Nichol et al. *NEJM* 2003; 348:1322-32.

## Stroke 10.2 Reporting and verification

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

## Hypertension

Indicator	Points	Payment stages
<b>Records</b>		
BP1. The practice can produce a register of patients with established hypertension	6	
<b>Ongoing management</b>		
BP4. The percentage of patients with hypertension in whom there is a record of the blood pressure in the preceding 9 months	16	40-90%
BP5. The percentage of patients with hypertension in whom the last blood pressure (measured in the preceding 9 months) is 150/90 or less	57	40-70%

### Hypertension - rationale for inclusion of indicator set

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

### Hypertension (BP) indicator 1

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

#### BP 1.1 Rationale

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

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

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

Elevated blood pressure readings of greater than 140/90 on three separate occasions are generally taken to confirm sustained high blood pressure.

Further information

British Hypertension Society Guidelines (2004). [www.bhsoc.org](http://www.bhsoc.org) (see guidelines). The routine surveillance of the patient population for hypertension is dealt with in the organisational indicators

NICE clinical guideline 34 (2006). Hypertension. Management of hypertension in adults in primary care. <http://guidance.nice.org.uk/CG34>

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

## **BP 1.2 Reporting and verification**

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

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

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

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

### **BP 4.1 Rationale**

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

British Hypertension Society Guidelines (2004). [www.bhsoc.org](http://www.bhsoc.org)

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

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

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

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

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

### **BP 5.1 Rationale**

For most patients an individual target of 140/85 is recommended. However, the BHSOC suggests an audit standard of 150/90 which has been adopted for the QOF.

For patients with diabetes mellitus, see indicators DM30 and DM31. For patients with chronic kidney disease, see indicator CKD3.

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

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



## Diabetes mellitus

Indicator	Points	Payment stages
<b>Records</b>		
DM19. The practice can produce a register of all patients aged 17 years and over with diabetes mellitus, which specifies whether the patient has Type 1 or Type 2 diabetes	6	
Ongoing management		
DM2. The percentage of patients with diabetes whose notes record BMI in the preceding 15 months	3	40-90%
DM26. The percentage of patients with diabetes in whom the last IFCC-HbA1c is 59mmol/mol (equivalent to HbA1c of 7.5% in DCCT values) or less (or equivalent test/reference range depending on local laboratory) in the preceding 15 months NICE menu ID: NM14	17	40-50%
DM27. The percentage of patients with diabetes in whom the last IFCC-HbA1c is 64mmol/mol (equivalent to HbA1c of 8% in DCCT values) or less (or equivalent test/reference range depending on local laboratory) in the preceding 15 months	8	40-70%
DM28. The percentage of patients with diabetes in whom the last IFCC-HbA1c is 75mmol/mol (equivalent to HbA1c of 9% in DCCT values) or less (or equivalent test/reference range depending on local laboratory) in the preceding 15 months	10	40-90%
DM21. The percentage of patients with diabetes who have a record of retinal screening in the preceding 15 months	5	40-90%
DM29. The percentage of patients with diabetes with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 15 months NICE menu ID: NM13	4	40-90%
DM10. The percentage of patients with diabetes with a record of neuropathy testing in the preceding 15 months	3	40-90%

DM30. The percentage of patients with diabetes in whom the last blood pressure is 150/90 or less NICE menu ID: NM01	8	40-71%
DM31. The percentage of patients with diabetes in whom the last blood pressure is 140/80 or less NICE menu ID: NM02	10	40-60%
DM13. The percentage of patients with diabetes who have a record of micro-albuminuria testing in the preceding 15 months (exception reporting for patients with proteinuria)	3	40-90%
DM22. The percentage of patients with diabetes who have a record of estimated glomerular filtration rate (eGFR) or serum creatinine testing in the preceding 15 months	3	40-90%
DM15. The percentage of patients with diabetes with a diagnosis of proteinuria or micro-albuminuria who are treated with ACE inhibitors (or A2 antagonists)	3	40-80%
DM17. The percentage of patients with diabetes whose last measured total cholesterol within the preceding 15 months is 5mmol/l or less	6	40-70%
DM18. The percentage of patients with diabetes who have had influenza immunisation in the preceding 1 September to 31 March	3	40-85%

## Diabetes - rationale for inclusion of indicator set

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

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

The SIGN website contains detailed evidence tables, and links to published articles. The English National Service Framework (NSF) for Diabetes website (<sup>35</sup>) also includes details of the evidence behind a range of recommendations. NICE has also published guidance on a number of aspects of diabetic control.

Further information

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

<sup>(35)</sup> [www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Diabetes/fs/en](http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Diabetes/fs/en)

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

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

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

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

Rather than including a substantial number of individual indicators, there has been discussion about whether a composite indicator such as "the percentage of diabetic patients who have had an annual check" would suffice. The view taken was that this would not make data collection any easier for GPs, since they would still have to satisfy their PCO at periodic visits that annual checks had included those items recommended in national guidance.

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

## Diabetes (DM) indicator 19

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

### Diabetes 19.1 Rationale

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

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

The World Health Organisation (WHO) 2006 criteria for the diagnosis of patients with diabetes mellitus are:

**random glucose test:** a glucose level above 11.1mmol/l taken at a random time on two occasions is a diagnosis of diabetes

**fasting glucose test:** a glucose level above 7.0mmol/l measured without anything to eat (usually overnight) and on two different days is also a diagnosis of diabetes

**glucose tolerance test:** a blood glucose test is taken two hours after a glucose drink is given to the patient. A level above 11.1mmol/l is a diagnosis of diabetes, while a

level below 7.8mmol/l is normal. However, if the level falls between these values the patient may have a decreased tolerance for glucose (known as impaired glucose tolerance or IGT).

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

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

As the care of children with diabetes mellitus is generally under the control of specialists, the register should exclude those patients aged 16 years and under.

Likewise, the indicators are not intended to apply to patients with gestational diabetes.

## **Diabetes 19.2 Reporting and verification**

The practice separately reports the numbers of patients on their diabetic register (aged 17 years and over) with Type 1 and Type 2 diabetes and the number of patients on their diabetic register (aged 17 years and over) with Type 1 and Type 2 diabetes as a proportion of their total list size.

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

Verification – in order to ensure that patients with diabetes are not 'lost' due to the use of high level diagnostic codes which do not specify whether the patient has type 1 or type 2 diabetes, a reported practice prevalence for this indicator should be compared with practice prevalence calculated using high level diagnostic codes. Reported practice prevalence should also be compared with national and expected prevalence.

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

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

### **Diabetes 2.1 Rationale**

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

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

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

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

The percentage of patients with diabetes in whom the last IFCC-HbA1c is 59mmol/mol (equivalent to HbA1c of 7.5% in DCCT values) or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months.

### Diabetes 26.1 Rationale

This indicator has been amended (from an HbA1c level of 7.0 to 7.5 per cent in DCCT values [53 to 59 mmol/mol]) following advice from the NICE QOF Advisory Committee in response to concern that a lower level of 7.0 per cent may have unintended consequences in terms of patient care because in order to achieve an average practice target of IFCC-HbA1c of 53mmol/mol (7.0 per cent) a clinician may need to aim for a IFCC-HbA1c below this in individual patients.

The three target levels for IFCC-HbA1c (59, 64 and 75 mmol/mol) in the QOF are designed to provide an incentive to improve glycaemic control across the distribution of IFCC-HbA1c values. The lower level may not be achievable or appropriate for all patients. Also practitioners should note that in the 2009 guideline for Type 2 diabetes, NICE advises against pursuing highly intensive management to levels below 48mmol/mol in certain patient subgroups<sup>(36)</sup>.

There is a near linear relationship between glycaemic control and death rate in people with type 2 diabetes<sup>(37)</sup>. In the EPIC Norfolk population cohort, a one per cent higher HbA1c was independently associated with 28 per cent higher risk of death, an association that extended below the diagnostic cut off for diabetes. These results suggest that, as with blood pressure and cholesterol, over the longer term at least, the lower the IFCC-HbA1c the better<sup>(38)</sup>.

However, the Action to Control Cardiovascular Risk in Diabetes (ACCORD) trial has highlighted the risks of adopting an aggressive treatment strategy for patients at risk of cardiovascular disease. In the trial's intervention group, HbA1c fell from 8.1 per cent to 6.4 per cent, but this was associated with increased mortality<sup>(39)</sup>. However, a recent meta-analysis did not confirm such an increase in risk<sup>(40)</sup> and reassuringly, the ADVANCE study<sup>(41)</sup> and the Veteran Affairs Diabetes Trial<sup>(42)</sup> found no increase in all-cause mortality in their intensive treatment groups. Also, long term follow-up of

<sup>(36)</sup> NICE clinical guideline 87 (2009). Type 2 diabetes: the management of type 2 diabetes.

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

<sup>(37)</sup> Khaw KT, Wareham N, Luben R et al. (2001) Glycated haemoglobin, diabetes, and mortality in men in Norfolk cohort of European prospective investigation of cancer and nutrition (EPIC-Norfolk). *BMJ*; 322: 15–18 – *see also next footnote*.

<sup>(38)</sup> Elley CR, Kenealy T, Robinson E et al. (2008) Glycated haemoglobin and cardiovascular outcomes in people with type 2 diabetes: a large prospective cohort study. *Diabetic Medicine*; 25: 1295–1301.

<sup>(39)</sup> Action to Control Cardiovascular Risk in Diabetes Study Group (2008) Effects of intensive glucose lowering in type 2 diabetes. *N Engl J Med*; 358: 2545–59

<sup>(40)</sup> Ray KK, Seshasai SR, Wijesuriya S et al. (2009) Effect of intensive control of glucose on cardiovascular outcomes and death in patients with diabetes mellitus: a meta-analysis of randomised controlled trials. *Lancet*; 373:1765-72

<sup>(41)</sup> ADVANCE Collaborative Group (2008) Intensive blood glucose control and vascular outcomes in patients with type 2 diabetes. *N Engl J Med*; 358: 2560–72.

<sup>(42)</sup> Duckworth W, Abraira C, Moritz T et al. (2009) Glucose control and vascular complications in veterans with type 2 diabetes. *N Engl J Med*; 360: 129–39.

the UK Prospective Diabetes Study demonstrated a ‘legacy effect’, with fewer deaths after ten years in those initially managed intensively <sup>(43)</sup>.

However, a newly published retrospective analysis of cohort data from the UK General Practice Research Database (GPRD) has reopened the debate about how low to aim <sup>(44)</sup>. The study found that, among people whose treatment had been intensified by the addition of insulin or a sulphonylurea, there was no benefit in reducing HbA1c below 7.5 per cent, although these differences were not statistically significant. The mortality rate was higher among those with the tightest control (this lowest decile of cohort had HbA1c below 6.7%; median = 6.4%). The reasons for these findings are unclear, but they raise further questions about the possibility of some groups of patients for whom a tight glycaemic target is inappropriate.

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

- Offer structured education to every person and/or their carer at and around the time of diagnosis, with annual reinforcement and review. Inform people and their carers that structured education is an integral part of diabetes care.
- Provide individualised and ongoing nutritional advice from a healthcare professional with specific expertise and competencies in nutrition.
- When setting a target glycated haemoglobin (HbA1c):
  1. involve the person in decisions about their individual IFCC-HbA1c target level, which may be above that of 48mmol/mol set for people with type 2 diabetes in general
  2. encourage the person to maintain their individual target unless the resulting side-effects (including hypoglycaemia) or their efforts to achieve this impair their quality of life
  3. offer therapy (lifestyle and medication) to help achieve and maintain the IFCC-HbA1c target level
  4. inform a person with a higher HbA1c that reduction in IFCC-HbA1c towards the agreed target is advantageous to future health
  5. avoid pursuing highly intensive management to levels of less than 48mmol/mol

The NICE and SIGN clinical guidelines are consistent <sup>(45)</sup>.

Given that there is strong evidence to support tight glycaemic control in Type 1 diabetes, which is reflected in current NICE and SIGN guidance, the revised indicator aims to balance risks and benefits for people with Type 2 diabetes. Younger people with little comorbidity are more likely to reap the benefits of tighter control, whereas less stringent goals may be more appropriate for people with established cardiovascular disease, those with a history of hypoglycaemia, or those requiring

---

<sup>(43)</sup> Holman RR, Paul SK, Bethel MA et al. (2008) 10-year follow-up of intensive glucose control in type 2 diabetes. *N Engl J Med*; 359: 1577–89.

<sup>(44)</sup> Currie CJ, Peters JR, Tynan A, et al. (2010) Survival as a function of HbA1c in people with type 2 diabetes: a retrospective cohort study. *The Lancet*; 375: 481–9.

<sup>(45)</sup> The American Diabetes Association, European Association for the Study of Diabetes, International Federation of Clinical Chemistry and Laboratory Medicine, and the International Diabetes Federation (2007) Consensus Statement on the Worldwide Standardization of the Hemoglobin A1C Measurement. *Diabetes Care*; 30: 2399-2400.

multiple medications or insulin to achieve a NICE suggested target IFCC-HbA1c of 48mmol/mol.

From June 2009 the way in which HbA1c results are reported in the UK has changed. A standard specific for HbA1c was prepared by the International Federation of Clinical Chemistry and Laboratory Medicine (IFCC) so that HbA1c reported by laboratories is traceable to the IFCC reference method and global comparison of HbA1c results is possible. From 1 June 2011, results will be reported only as IFCC-HbA1c mmol/mol (see table 2).

**Table 2: IFCC values expressed as mmol/mol**

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

## Diabetes 26.2 Reporting and verification

The practice reports the percentage of patients on the diabetic register in which the last IFCC-HbA1c measurement was 59mmol/mol or less (value 7.5 per cent or less). The test must have been carried out in the preceding 15 months.

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

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

## Diabetes (DM) indicator 27

The percentage of patients with diabetes in whom the last IFCC-HbA1c is 64mmol/mol (equivalent to HbA1c of 8% in DCCT values) or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months.

## **Diabetes 27.1 Rationale**

See DM 26.1.

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

## **Diabetes 27.2 Reporting and verification**

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

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

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

## **Diabetes (DM) indicator 28**

The percentage of patients with diabetes in whom the last IFCC-HbA1c is 75mmol/mol (equivalent to HbA1c of 9% in DCCT values) or less (or equivalent test/reference range depending on local laboratory) in the preceding 15 months.

## **Diabetes 28.1 Rationale**

See DM 26.1

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

## **Diabetes 28.2 Reporting and verification**

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

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

1. inspection of the output from a computer search that has been used to provide information on this indicator
2. inspection of a sample of records of patients with diabetes to look at the proportion with last recorded IFCC-HbA1c 75 mmol/mol or less



- inspection of a sample of records of patients for whom a record of IFCC-HbA1c 75 mmol/mol or less is claimed, to see if there is evidence of this in the medical records.

## **Diabetes (DM) indicator 21**

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

### **Diabetes 21.1 Rationale**

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

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

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

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

### **Diabetes 21.2 Reporting and verification**

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

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

## **Diabetes (DM) indicator 29 (NICE Menu NM13)**

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

### **Diabetes 29.1 Rationale**

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

The foot inspection and assessment should include:

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

The NICE guideline on Type 2 diabetes: the prevention and management of foot problems <sup>(46)</sup> advises that foot risk should be classified as:

- at low current risk: normal sensation, palpable pulses
- at increased risk: neuropathy or absent pulses or other risk factor
- at high risk: neuropathy or absent pulses plus deformity or skin changes or previous ulcer
- ulcerated foot

The practitioner carrying out the inspection and assessment should:

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

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

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

## **Diabetes 29.2 Reporting and verification**

The practice reports the percentage of patients on the diabetic register who have had a foot examination within the preceding 15 months that classifies the level of risk as follows: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes or previous ulcer) or 4) ulcerated foot.

---

<sup>(46)</sup> NICE clinical guideline 10 (2004). Type 2 diabetes: prevention and management of foot problems. [www.nice.org.uk/guidance/CG10](http://www.nice.org.uk/guidance/CG10)

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

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

### **Diabetes 10.1 Rationale**

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

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

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

Further information

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

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

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

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

## **Diabetes (DM) Indicator 30 (NICE menu NM01)**

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

### **Diabetes 30.1 Rationale**

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

This indicator, along with indicator DM31 are replacements to the 2009/10 indicator DM12 (the percentage of patients with diabetes in whom the last blood pressure is 145/85 or less). DM31 sets a target of 140/80 mm/Hg as per the target recommended

by NICE<sup>(47)</sup> while the target of 150/90 mm/Hg has been set as per the target for those people who cannot manage this, such as those with retinopathy, microalbuminuria or cerebrovascular disease.

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

## **Diabetes 30.2 Reporting and verification**

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

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

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

#### **Diabetes 31.1 Rationale**

Blood pressure (BP) lowering in people with diabetes reduces the risk of macrovascular and microvascular disease.

This indicator, along with indicator DM30, are replacements of the 2009/10 QOF indicator DM12 (The percentage of patients with diabetes in whom the last blood pressure is 145/85 or less). The target of 140/80 mm/Hg has been set per the target recommended by NICE.

## **Diabetes 31.2 Reporting and verification**

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

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

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

#### **Diabetes 13.1 Rationale**

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

---

<sup>(47)</sup> NICE clinical guidance 87 (2008). Type 2 Diabetes – newer agents (partial update of CG66). [www.nice.org.uk/CG87](http://www.nice.org.uk/CG87).

diabetes should have their urinary albumin concentration and serum creatinine measured at diagnosis and at regular intervals, usually annually.

Further information

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

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

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

## **Diabetes 13.2 Reporting and verification**

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

## **Diabetes (DM) indicator 22**

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

### **Diabetes 22.1 Rationale**

See DM 13.1

Estimated glomerular filtration rate (eGFR), based on serum creatinine is reported as a better means to detect and monitor early renal disease and has been routinely reported since 2006.

### **Diabetes 22.2 Reporting and verification**

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

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

## **Diabetes (DM) indicator 15**

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

## Diabetes 15.1 Rationale

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

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

Further information

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

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

## Diabetes 15.2 Reporting and verification

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

## Diabetes (DM) indicator 17

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

## Diabetes 17.1 Rationale

In patients whose total cholesterol is greater than 5.0mmol/l, statin therapy to reduce cholesterol should be initiated and titrated as necessary to reduce total cholesterol to less than 5mmol/l. There is ongoing debate concerning the intervention levels of serum cholesterol in diabetic patients who do not apparently have CVD.

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

Further information

Heart Protection Study Collaborative Group. MRC/BHF Heart Protection Study of cholesterol-lowering with simvastatin in 5963 people with diabetes: a randomised placebo-controlled trial <sup>(48)</sup>.

Mortality from CHD in Subjects with Type 2 Diabetes and in Nondiabetic Subjects with and without Prior Myocardial Infarction Haffner et al <sup>(49)</sup>.

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

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

---

<sup>(48)</sup> *Lancet* 2003; 361:2005-2016.

<sup>(49)</sup> *NEJM* 1998; 339: 229-234.

## **Diabetes 17.2 Reporting and verification**

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

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

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

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

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

### **Diabetes 18.1 Rationale**

This is a current recommendation from the Scottish Government and the Joint Committee on Vaccination and Immunisation (JCVI).

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

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

## Chronic obstructive pulmonary disease (COPD)

Indicator	Points	Payment stages
<b>Records</b>		
COPD14. The practice can produce a register of patients with COPD	3	
<b>Initial diagnosis</b>		
COPD15. The percentage of all patients with COPD diagnosed after 1 April 2011 in whom the diagnosis has been confirmed by post bronchodilator spirometry	5	40-80%
<b>Ongoing management</b>		
COPD10. The percentage of patients with COPD with a record of FEV1 in the preceding 15 months	7	40-70%
COPD13. The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the MRC dyspnoea score in the preceding 15 months	9	50-90%
COPD8. The percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March	6	40-85%

### COPD - rationale for inclusion of indicator set

Chronic Obstructive Pulmonary Disease (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 healthcare team with onward referral to secondary care when required. This indicator set focuses on the diagnosis and management of patients with symptomatic COPD.

COPD indicator 14

The practice can produce a register of patients with COPD.

### COPD 14.1 Rationale

A register is a prerequisite for monitoring patients with COPD.



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

See COPD 15.1.

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

NICE clinical guideline 101 recommended a change to the diagnostic threshold for COPD (see table 3). As this may lead to an increase in the recorded prevalence of COPD, this indicator has been renumbered from April 2011 in recognition of this.

**Table 3: Gradation of severity of airflow obstruction**

		NICE clinical guideline 12 (2004)	ATS/ERS <sup>(50)</sup> 2004	GOLD 2008 <sup>(51)</sup>	NICE clinical guideline 101 (2010)
<b>Post-bronchodilator FEV1/FVC</b>	<b>FEV1 % predicted</b>	<b>Severity of airflow obstruction</b>			
			Post-bronchodilator	Post-bronchodilator	Post-bronchodilator
< 0.7	≥ 80%		Mild	Stage 1 – Mild	Stage 1 – Mild*
< 0.7	50–79%	Mild	Moderate	Stage 2 – Moderate	Stage 2 – Moderate
< 0.7	30–49%	Moderate	Severe	Stage 3 – Severe	Stage 3 – Severe
< 0.7	< 30%	Severe	Very severe	Stage 4 – Very severe**	Stage 4 – Very severe**

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

\*\*Or FEV<sub>1</sub> < 50% with respiratory failure.

## COPD 14.2 Reporting and verification

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

<sup>(50)</sup> Celli BR, MacNee W (2004) Standards for the diagnosis and treatment of patients with COPD: a summary of the ATS/ERS position paper. *European Respiratory Journal* 23(6): 932–46.

<sup>(51)</sup> Global Initiative for Chronic Obstructive Lung Disease (GOLD) (2008). Global strategy for the diagnosis, management, and prevention of COPD.

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

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

## **COPD indicator 15**

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

### **COPD 15.1 Rationale**

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

NICE clinical guidelines provide the following definition of COPD:

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

The NICE guidelines require post bronchodilator spirometry for diagnosis and gradation of severity of airways obstruction. Failure to use post bronchodilator readings has been shown to overestimate the prevalence of COPD by 25 per cent<sup>(52)</sup>. Spirometry should be performed after the administration of an adequate dose of an inhaled bronchodilator (e.g. 400mcg salbutamol).

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

Routine reversibility testing is not recommended. However, where doubt exists as to whether the diagnosis is asthma or COPD, reversibility testing may add additional information to post bronchodilator readings alone and peak flow charts are useful. It is acknowledged that COPD and asthma can co-exist and that many patients with asthma who smoke will eventually develop irreversible airways obstruction. Where asthma is present, these patients should be managed as asthma patients as well as COPD patients. This will be evidenced by a greater than 400mls response to a reversibility test and a post bronchodilator FEV<sub>1</sub> of less than 80 per cent of predicted normal as well as an appropriate medical history.

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

Further information

---

<sup>(52)</sup> Johannesessen et al. *Thorax* 2005; 60(10): 842-847.

NICE clinical guideline 101 (2010). Chronic obstructive pulmonary disease. <http://guidance.nice.org.uk/CG101/NICEGuidance/pdf/English>

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

## **COPD 15.2 Reporting and verification**

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

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

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

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

## **COPD indicator 10**

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

### **COPD 10.1 Rationale**

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

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

Further information

NICE clinical guideline 101 - see table 6.

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

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

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

Referral for consideration for long term oxygen therapy and/or pulmonary rehabilitation should be made to those with appropriate training and expertise. This may include a respiratory physician, a general physician or a GP with a special interest (GPwSI) in respiratory disease. The specific clinical criteria for referral for long term oxygen therapy and pulmonary rehabilitation are set out in NICE clinical guideline 101.

## **COPD 10.2 Reporting and verification**

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

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

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

## **COPD indicator 13**

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

## **COPD 13.1 Rationale**

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

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

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

A tool such as the Clinical COPD Questionnaire could be used to assess current health status <sup>(53)</sup>.

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

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

## **COPD 13.2 Reporting and verification**

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

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

## **COPD indicator 8**

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

### **COPD 8.1 Rationale**

This is a current recommendation from the Scottish Government and the Joint Committee on Vaccination and Immunisation (JCVI).

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

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

---

<sup>(53)</sup> Clinical COPD Questionnaire. <http://www.ccq.nl/>

## Epilepsy

Indicator	Points	Payment stages
<b>Records</b>		
EPILEPSY 5. The practice can produce a register of patients aged 18 years and over receiving drug treatment for epilepsy	1	
<b>Ongoing management</b>		
EPILEPSY 6. The percentage of patients age 18 years and over on drug treatment for epilepsy who have a record of seizure frequency in the preceding 15 months	4	40-90%
EPILEPSY 8. The percentage of patients age 18 years and over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the preceding 15 months	6	40-70%
EPILEPSY 9. The percentage of women under the age of 55 years who are taking antiepileptic drugs who have a record of information and counselling about contraception, conception and pregnancy in the preceding 15 months NICE menu ID: NM03	3	40-90%

### Epilepsy - rationale for inclusion of indicator set

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

### Epilepsy indicator 5

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

### Epilepsy 5.1 Rationale

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

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

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

## **Epilepsy 5.2 Reporting and verification**

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

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

## **Epilepsy indicator 6**

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

## **Epilepsy 6.1 Rationale**

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

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

NICE clinical guideline 20 suggests that 'all individuals with epilepsy should have a regular structured review ...in adults this review should be carried out at least yearly by either a generalist or a specialist'. This guidance therefore supports the current epilepsy indicators which are in essence the component parts of an annual structured face to face review, where clinically appropriate. An updated version of this guidance was in progress at the time of publication of this document. The updated guidance will be published on the NICE website once available.

Further information

NICE clinical guideline 20 (2004). The diagnosis and management of the epilepsies in adults and children in primary and secondary care.  
<http://guidance.nice.org.uk/CG20/NICEGuidance/pdf/English>

SIGN clinical guideline 70 (2003). Diagnosis and management of epilepsy in adults.  
<http://www.sign.ac.uk/guidelines/fulltext/70/index.html>

## **Epilepsy 6.2 Reporting and verification**

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

## **Epilepsy indicator 8**

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

### **Epilepsy 8.1 Rationale**

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

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

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

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

[http://www.epilepsyscotland.org.uk/information\\_section/healthpro/information\\_healthpro.html](http://www.epilepsyscotland.org.uk/information_section/healthpro/information_healthpro.html)

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

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

## **Epilepsy Indicator 9 (NICE menu NM03)**

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

### **Epilepsy 9.1 Rationale**

It is estimated that in the UK 131,000 women with epilepsy are of child bearing age (12 – 50 years). Approximately 25 per cent of all people with epilepsy are women of reproductive age and 1 in 200 women attending antenatal clinics are receiving antiepileptic drugs (AEDs) <sup>(54)</sup>. Around 2500 women with epilepsy will have a baby each year in the UK.

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

---

<sup>(54)</sup> Royal Society of Medicine (2004). Primary care guidelines for the management of females with epilepsy. [www.rsmpress.co.uk/epilepsy\\_web.pdf](http://www.rsmpress.co.uk/epilepsy_web.pdf)



per cent<sup>(55)</sup>. The risk of MCMs occurring can relate to having epilepsy and to taking AEDs while pregnant.

In a survey of women with epilepsy, only 28 per cent of participants aged 19 – 34 years have received information about oral contraception and epilepsy medication<sup>(56)</sup>. In the same group, 71 per cent said that the risk of epilepsy and/or an AED affecting the unborn child is an important issue. Only 46 per cent of women with epilepsy who have had children had been told before conceiving or during pregnancy that their medication might affect their unborn child.

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

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

SIGN clinical guideline 70 on epilepsy states:

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

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

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

## **Epilepsy 9.2 Reporting and verification**

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

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

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

---

<sup>(55)</sup> Morrow J, Russell A, Guthrie E et al. (2006) Malformation risks of antiepileptic drugs in pregnancy: a prospective study from the UK Epilepsy and Pregnancy Register. *Journal of Neurology, Neurosurgery and Psychiatry* 77: 193–8.

<sup>(56)</sup> Crawford P, Hudson S (2003) Understanding the information needs of women with epilepsy at different lifestages: results of the 'Ideal World' survey. *Seizure* 12: 502–7.

## Hypothyroid

Indicator	Points	Payment stages
<b>Records</b>		
THYROID 1. The practice can produce a register of patients with hypothyroidism	1	
<b>Ongoing management</b>		
THYROID 2. The percentage of patients with hypothyroidism with thyroid function tests recorded in the preceding 15 months	6	40-90%

### Hypothyroidism - rationale for inclusion of indicator set

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

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

### THYROID indicator 1

The practice can produce a register of patients with hypothyroidism.

#### Thyroid 1.1 Rationale

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

#### Thyroid 1.2 Reporting and verification

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

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

## THYROID indicator 2

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

### Thyroid 2.1 Rationale

There is no clear evidence on the appropriate frequency of TSH (thyroid stimulating hormone)/T4 measurement. However, the consensus group on thyroid disease recommended an annual check of TSH/T4 levels in all patients treated with thyroxine. In addition they recommend an annual check in patients previously treated with radioiodine or partial thyroidectomy<sup>(57)</sup>.

### Thyroid 2.2 Rationale

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

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

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

---

<sup>(57)</sup> Consensus statement for good practice and audit measures in the management of hypothyroidism and hyperthyroidism. BMJ 1996; 313: 539-544.

## Cancer

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

### Cancer - rationale for inclusion of indicator set

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

### Cancer Indicator 1

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

#### Cancer 1.1 Rationale

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

#### Cancer 1.2 Reporting and verification

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

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

### **Cancer indicator 3**

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

#### **Cancer 3.1 Rationale**

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

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

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

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

Further information

Better Cancer Care: An Action Plan.

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

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

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

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

## Palliative care

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

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

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

In Scotland, “Living and Dying Well, a national action plan for palliative and end of life care in Scotland”<sup>(58)</sup> places great emphasis on the role of primary care in providing palliative care for all patients with such needs, regardless of diagnosis. The action plan uses the concepts of planning and delivery of care, and of communication and information sharing as a framework to support a person centred approach to delivering consistent palliative and end of life care in Scotland.

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

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

<sup>(58)</sup> Living and Dying Well, a national action plan for palliative and end of life care in Scotland (2008). <http://www.scotland.gov.uk/Publications/2008/10/01091608/0>

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

The introduction of the Gold Standard Framework (GSF) to primary care and its associated audit tool, the ADA are associated with a considerable degree of research and evaluation. The GSF provides ideas and tools that help practices to focus on implementing high quality patient centred care.

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

### **Palliative care (PC) indicator 3**

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

#### **Palliative care 3.1 Rationale**

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

**Identifying** patients in need of palliative care, **assessing** their needs and preferences and proactively **planning** their care, are the key steps in the provision of high quality care at the end of life in general practice. This indicator set is focused on the maintenance of a register (identifying the patients) and on regular multidisciplinary meetings where the team can ensure that all aspects of a patient’s care have been assessed and future care can be co-ordinated and planned proactively <sup>(59)</sup>.

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

1. Their death in the next 12 months can be reasonably predicted (rather than trying to predict, clinicians often find it easier to ask themselves ‘the surprise question’ – ‘Would I be surprised if this patient were still alive in 12 months?’)
2. They have advanced or irreversible disease and clinical indicators of progressive deterioration and thereby a need for palliative care e.g. they have one core and one disease specific indicator in accordance with the GSF Prognostic Indicators Guidance (see QOF section of GSF website).

---

<sup>(59)</sup> In one PCT 40 per cent of patients who died in hospital in October 2007 did not have medical needs which required them to be treated in hospital, and nearly a quarter of these had been in hospital for over a month’ NAO End of Life Care report November 2008).

3. They are entitled to a DS 1500 form (the DS 1500 form is designed to speed up the payment of financial benefits and can be issued when a patient is considered to be approaching the terminal stage of their illness. For these purposes, a patient is considered as terminally ill if they are suffering from a progressive disease and are not expected to live longer than six months)

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

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

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

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

### **Palliative care indicator 2**

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

### **Palliative care 2.1 Rationale**

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

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

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

Scottish practices participating in the Palliative Care DES will have access to a reporting template which can be used and adapted for this purpose and available at annex D of the DES:

[http://www.sehd.scot.nhs.uk/pca/PCA2008\(M\)12.pdf](http://www.sehd.scot.nhs.uk/pca/PCA2008(M)12.pdf)



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

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

## Mental health

Indicator	Points	Payment stages
<b>Records</b>		
MH8. The practice can produce a register of people with schizophrenia, bipolar affective disorder and other psychoses	4	
<b>Ongoing management</b>		
MH11. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months NICE menu ID: NM15	4	40-90%
MH12. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 15 months NICE menu ID: NM16	4	40-90%
MH13. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 15 months NICE menu ID: NM17	4	40-90%
MH14. The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol:hdl ratio in the preceding 15 months NICE menu ID: NM18	5	40-80%
MH15. The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose in the preceding 15 months NICE menu ID: NM19	5	40-80%
MH16. The percentage of women (aged from 25 to 64 in England and Northern Ireland, from 20 to 60 in Scotland and from 20 to 64 in Wales) with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding five years. NICE menu ID: NM20	5	40-80%
MH17. The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months NICE menu ID: NM21	1	40-90%

MH18. The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months NICE menu ID: NM22	2	40-90%
MH10. The percentage of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate	6	25-50%

## Mental health

### Mental health - rationale for inclusion of indicator set

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

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

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

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

### Mental health indicators MH11 – MH16

In the 2009/10 indicator MH9, it was recommended that patients should receive an annual health promotion and prevention review and advice appropriate to their age, gender and health status.

From 1 April 2011, the components of the 2009/10 indicator MH9 have been separated out to create a series of indicators that define a physical health review. The annual timeframe for these indicators is in line with NICE clinical guideline on schizophrenia <sup>(60)</sup>.

NICE clinical guideline 38 on bipolar disorder <sup>(61)</sup> recommends that patients with bipolar disorder should have an annual physical health review, normally in primary care, to ensure that the following are assessed each year:

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

<sup>(60)</sup> NICE clinical guideline 82 (2009). Schizophrenia. Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care. [www.nice.org.uk/guidance/CG82](http://www.nice.org.uk/guidance/CG82).

<sup>(61)</sup> NICE clinical guideline 38 (2006). Bipolar disorder. The management of bipolar disorder in adults, children and adolescents, in primary and secondary care. [www.nice.org.uk/guidance/CG38](http://www.nice.org.uk/guidance/CG38).

- plasma glucose levels
- weight
- smoking status and alcohol use
- blood pressure

In addition to lifestyle factors, such as smoking, poor diet and lack of exercise, antipsychotic drugs vary in their liability for metabolic side-effects, such as weight gain, lipid abnormalities and disturbance of glucose regulation. Specifically, they increase the risk of the metabolic syndrome, a recognised cluster of features (hypertension, central obesity, glucose intolerance or insulin resistance and dyslipidaemia), which is a predictor of type 2 diabetes and CHD <sup>(62)</sup>.

## **Mental health (MH) indicator 8**

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

### **Mental health 8.1 Rationale**

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

### **Remission from serious mental illness**

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

Making an accurate diagnosis of remission for a patient with a diagnosis of serious mental illness can be challenging and the evidence base to support when to use the ‘remission code’ is largely based on clinical judgment. A recent longitudinal international study of recovery from psychotic illnesses found that as many as 56 per cent of patients recovered from psychotic illnesses to some extent, although only 16 per cent recover if a more stringent concept of recovery <sup>(63)</sup> is used.

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

- where there is no record of antipsychotic medication
- with no mental health in-patient episodes; and

<sup>(62)</sup> Mackin P, Bishop D, Watkinson H et al. (2007) Metabolic disease and cardiovascular risk in people treated with antipsychotics in the community. *Br J Psychiatry* 191: 23–9.

<sup>(63)</sup> Harrison, G., Hopper, K., Craig, T., Laska, E., Siegel, C., Wanderling, J. et al. (2001) Recovery from psychotic illness: A 15- and 25-year international follow-up study. *British Journal of Psychiatry*, 178:506-517.

- no secondary or community care mental health follow-up for at least five years.

From 1 April 2011 practices may record patients as being in remission. Where a patient is recorded as being ‘in remission’ they remain on the register (in case their condition relapses at a later date) but they are excluded from indicators MH10 – MH16 inclusive.

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

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

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

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

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

## **Mental Health (MH) indicator 11 (NICE menu NM15)**

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

## **Mental health 11.1 Rationale**

Substance misuse by people with schizophrenia is increasingly recognised as a major problem, both in terms of its prevalence and its clinical and social effects<sup>(64)</sup>. The National Psychiatric Morbidity Survey in England found that 16 per cent of people with schizophrenia were drinking over the recommended limits of 21 units of alcohol

---

<sup>(64)</sup> Banerjee S, Clancy C, Crome I, editors (2001) Co-existing problems of mental disorder and substance misuse (dual diagnosis). An information manual. London: Royal College of Psychiatrists’ Research and Training Unit.

for men and 14 units or alcohol for women a week<sup>(65)</sup>,<sup>(66)</sup>. Bipolar disorder is also highly comorbid with alcohol and other substance abuse<sup>(67)</sup>.

## Mental health 11.2 Reporting and verification

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

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

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

## Mental health 12.1 Rationale

The general population in developed countries is experiencing an escalation in cardiovascular risk factors, such as obesity and lack of exercise, and increased rates of type 2 diabetes mellitus. Superimposed on this are lifestyle issues (not all actively chosen) for people with psychosis, generating an escalation of cardiovascular risks<sup>(68)</sup>.

In particular, people with psychosis may lead more sedentary lives, eat less fruit and vegetables, be much more likely to be obese, are two to three times more likely to smoke cigarettes, and five times more likely to smoke heavily<sup>(69)</sup>. In addition to lifestyle factors, antipsychotic drugs vary in their liability for metabolic side-effects, such as weight gain, lipid abnormalities and disturbance of glucose regulation. Specifically, they increase the risk of the metabolic syndrome, a recognised cluster of features (hypertension, central obesity, glucose intolerance or insulin resistance, and dyslipidaemia), which is a predictor of Type 2 diabetes and CHD<sup>(70)</sup>.

Approximately 40 per cent of people with schizophrenia are obese<sup>(71)</sup> and obesity is also common in people with bipolar disorders<sup>(72)</sup>.

NICE clinical guideline 43 (2006). Obesity. The prevention, identification, assessment and management of overweight and obesity in adults and children. <http://guidance.nice.org.uk/CG43>

---

<sup>(65)</sup> Meltzer H, Gill B, Pettigrew M et al. (1996) OPCS Survey of Psychiatric Morbidity in Great Britain. Report 3: Economic activity and social functioning of adults with psychiatric disorders. London: HMSO.

<sup>(66)</sup> Farrell M, Howes S, Taylor C et al. (1998) Substance misuse and psychiatric comorbidity: an overview of the OPCS National Psychiatric Morbidity Survey. *Addictive Behaviors* 23: 909–18.

<sup>(67)</sup> Kessler RC, Rubinow DR, Holmes C et al. (1997) The epidemiology of DSM-III-R bipolar I disorder in a general population survey. *Psychological Medicine* 27: 1079–89.

<sup>(68)</sup> Heiskanen T, Niskanen L, Lyytikäinen R et al. (2003) Metabolic syndrome in patients with schizophrenia. *J Clin Psychiatry* 64: 575–9.

<sup>(69)</sup> McCreddie R, MacDonald E, Blacklock C et al. (1998) Dietary intake of schizophrenic patients in Nithsdale, Scotland: case-control study. *BMJ* 317: 784–5

<sup>(70)</sup> Mackin P, Bishop D, Watkinson H et al. (2007) Metabolic disease and cardiovascular risk in people treated with antipsychotics in the community. *Br J Psychiatry* 191: 23–9.

<sup>(71)</sup> Hennekens C, Hennekens A, D Hollar (2005) Schizophrenia and increased risks of cardiovascular disease. *Am Heart J* 150: 1115–21.

<sup>(72)</sup> Elmsie JL, Silverstone JT, Mann JI et al. (2000) Prevalence of overweight and obesity in bipolar patients. *Journal of Clinical Psychiatry* 61: 179–84.

SIGN guideline 115 (2010). Management of obesity.  
<http://www.sign.ac.uk/guidelines/fulltext/115/index.html>

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

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

## **Mental Health (MH) indicator 13 (NICE menu NM17)**

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

## **Mental health 13.1 Rationale**

People with schizophrenia have a mortality of between two and three times that of the general population and most of the excess deaths are from diseases that are the major causes of death in the general population. A recent prospective record linkage study of the mortality of a community cohort of 370 people with schizophrenia found that the increased mortality risk is probably life-long, and it suggested that the cardiovascular mortality of schizophrenia has increased over the past 25 years relative to the general population <sup>(73)</sup>. The NICE clinical guideline on bipolar disorder also states that the standardised mortality ratio for cardiovascular death may be twice that of the general population but appears to be reduced if patients adhere to long term medication.

Hypertension in people with schizophrenia is estimated at 19 per cent compared with 15 per cent in the general population <sup>(74)</sup>. A cross-sectional study of 4310 patients diagnosed with bipolar disorder in 2001 receiving care at veterans' administration facilities found a prevalence of hypertension of 35 per cent <sup>(75)</sup>.

There is evidence to suggest that physical conditions such as cardiovascular disorders go unrecognised in psychiatric patients. A direct comparison of cardiovascular screening (blood pressure, lipid levels and smoking status) of people with asthma, people with schizophrenia and other attendees indicated that practices were less likely to screen people with schizophrenia for cardiovascular risk compared with the other two groups <sup>(76)</sup>.

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

---

<sup>(73)</sup> Brown S, Kim M, Mitchell C et al. (2010) 25 year mortality of a community cohort with schizophrenia. *Br J Psychiatr* 196:116–21.

<sup>(74)</sup> Hennekens C, Hennekens A, Hollar D (2005) Schizophrenia and increased risks of cardiovascular disease. *Am Heart J* 150: 1115–21.

<sup>(75)</sup> Kilbourne AM, Cornelius JR, Han X et al. (2004) Burden of general medical conditions among individuals with bipolar disorder. *Bipolar Disorder* 6: 368–73.

<sup>(76)</sup> Roberts L, Roalfe A, Wilson S et al. (2007) Physical health care of patients with schizophrenia in primary care: a comparative study. *Fam Pract* 24: 34–40.

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

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

### **Mental Health (MH) indicator 14 (NICE menu NM18)**

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

#### **Mental health 14.1 Rationale**

A cross-sectional study of 4310 patients diagnosed with bipolar disorder in 2001 receiving care at veterans' administration facilities found a prevalence of hyperlipidaemia of 23 per cent<sup>(77)</sup>. People with schizophrenia also have a much higher risk of raised total cholesterol:hdl ratio than the general population<sup>(78)</sup>.

## **Mental health 14.2 Reporting and verification**

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

### **Mental Health (MH) indicator 15 (NICE menu NM19)**

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

#### **Mental health 15.1 Rationale**

A cross-sectional study of 4310 patients diagnosed with bipolar disorder in 2001 receiving care at veterans' administration facilities found a prevalence of diabetes of 17 per cent<sup>(79)</sup>. The relative risk of developing diabetes mellitus is two to three times higher in people with schizophrenia than in the general population<sup>(80)</sup>.

The NICE QOF Advisory Committee noted that there was lack of evidence to support the use of blood glucose testing in all people with schizophrenia, bipolar affective disorder and other psychoses and therefore recommended that an age limit of 40 years or above should be applied to this indicator.

---

<sup>(77)</sup> Kilbourne AM, Cornelius JR, Han X et al. (2004) Burden of general medical conditions among individuals with bipolar disorder. *Bipolar Disorder* 6: 368–73.

<sup>(78)</sup> Oud M, Meyboom-de Jong B (2009) Somatic diseases in patients with schizophrenia in general practice: their prevalence and health care. *BMC Family Practice* 10: 32

<sup>(79)</sup> Kilbourne AM, Cornelius JR, Han X, et al. (2004) Burden of general medical conditions among individuals with bipolar disorder. *Bipolar Disorder* 6: 368–73.

<sup>(80)</sup> Oud M, Meyboom-de Jong B (2009) Somatic diseases in patients with schizophrenia in general practice: their prevalence and health care. *BMC Family Practice* 10: 32.



This indicator is intended to encourage case finding of diabetes in those with a serious mental illness through the use of random or fasting blood glucose measurements. Patients in whom diabetes has already been diagnosed will be excluded from the denominator of this indicator. They should be managed according to the diabetes indicator set.

## **Mental health 15.2 Reporting and verification**

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

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

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

### **Mental health 16.1 Rationale**

A recent report by the Disability Rights Commission based on the primary care records of 1.7 million primary care patients found that women with schizophrenia were less likely to have had a cervical sample taken in the previous five years (63 per cent) compared with the general population (73 per cent). This did not apply to patients with bipolar affective disorder<sup>(81)</sup>. This finding may reflect an underlying attitude that such screening is less appropriate for women with schizophrenia. This indicator therefore encourages practices to ensure that women with schizophrenia, bipolar affective disorder or other psychoses are given cervical screening according to devolved national guidelines.

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

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

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

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

### **Mental health 17.1 Rationale**

It is important to check thyroid and renal function regularly in patients taking lithium, since there is a much higher than normal incidence of hypothyroidism and

---

<sup>(81)</sup> Hippisley-Cox J, Pringle M (2005). Health inequalities experienced by people with schizophrenia and manic depression: Analysis of general practice data in England and Wales. Nottingham: QRESEARCH. [www.qresearch.org/SitePages/publications.aspx](http://www.qresearch.org/SitePages/publications.aspx)

hypercalcaemia, and of abnormal renal function tests in patients on lithium. Overt hypothyroidism has been found in between eight per cent and 15 per cent of people on lithium.

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

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

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

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

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

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

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

### **Mental health 18.1 Rationale**

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

The National Patient Safety Agency (NPSA) recently conducted a review of the use of oral lithium treatment for bipolar disorder, which demonstrated that wrong or unclear dose or strength, and monitoring were key issues for lithium therapy<sup>(82)</sup>. A search of all medication incidents related to the use of lithium reported to the National Reporting and Learning System between November 2003 and December 2008 identified a total of 567 incidents. Two of these resulted in ‘severe’ harm to the patient, although the majority were reported as ‘no harm’ events<sup>(83)</sup>.

---

<sup>(82)</sup> NPSA. Patient safety alert 0921(2009). Safer lithium therapy. [www.nrls.npsa.nhs.uk/alerts](http://www.nrls.npsa.nhs.uk/alerts)

<sup>(83)</sup> Prescribing Observatory for Mental Health (2009). Topic 7 baseline report. Monitoring of patients prescribed lithium: baseline.

The NICE clinical guideline on bipolar disorder <http://www.nice.org.uk/nicemedia/live/10990/30193/30193.pdf> states that for patients with bipolar disorder on lithium treatment, prescribers should:

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

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

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

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

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

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

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

## **Mental health (MH) indicator 10**

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

### **Mental health 10.1 Rationale**

This indicator reflects good professional practice and supported by NICE clinical guidelines <sup>(84)</sup>.

---

<sup>(84)</sup> NICE clinical guideline 82 (2009). Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care.

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

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

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

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

1. Patient's current health status and social care needs including how needs are to be met, by whom, and the patient's expectations.
2. How socially supported the individual is: e.g. friendships/family contacts/voluntary sector organisation involvement.
3. People with mental health problems have fewer social networks than average, with many of their contacts related to health services rather than sports, family, faith, employment, education or arts and culture. One survey found that 40 per cent of people with ongoing mental health problems had no social contacts outside mental health services <sup>(85)</sup>.
4. Co-ordination arrangements with secondary care and/or mental health services and a summary of what services are actually being received.
5. Occupational status.
6. In England, only 24 per cent of people with mental health problems are currently in work, the lowest employment rate of any group of people (ONS Labour Force Survey, Autumn 2003). People with mental health problems also earn only two thirds of the national average hourly rate (ONS, 2002). Studies show a clear interest in work and employment activities amongst users of mental health services with up to 90 per cent wishing to go into or back to work <sup>(86)</sup>.
7. Early Warning Signs.
8. "Early warning signs" from the patient's perspective that may indicate a possible relapse <sup>(87)</sup>. Many patients may already be aware of their early warning signs (or relapse signature) but it is important for the primary care team to also be aware of noticeable changes in thoughts, perceptions, feelings and behaviours leading up to their most recent episode of illness as well as any events the person thinks may have acted as triggers.

---

<sup>(85)</sup> See Ford et al. *Psychiatric Bulletin* 1993; 17(7): 409-411 and Office of the Deputy Prime Minister, *Mental health and social exclusion (Social Exclusion Unit Report)*. London, ODPM, 2004.

<sup>(86)</sup> See Grove and Drurie. *(Social firms: an instrument for social and economic inclusion)*. Redhill, Social Firms UK, 1999.

<sup>(87)</sup> See Birchwood et al. *Advances in Psychiatric Treatment* 2000; 6: 93-101 and Birchwood and Spencer. *Clinical Psychology Review* 2001; 21(8): 1211-26.

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

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

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

Further information

The Mental Health (Care and Treatment) (Scotland) Act 2003.  
[www.opsi.gov.uk/legislation/scotland/acts2003/asp\\_20030013\\_en\\_1](http://www.opsi.gov.uk/legislation/scotland/acts2003/asp_20030013_en_1)

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

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

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

## Asthma

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

### Asthma - rationale for inclusion of indicator set

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

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

### Asthma indicator 1

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

### Asthma 1.1 Rationale

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

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

One of the main difficulties in asthma is the variable and intermittent nature of asthma. Some of the symptoms of asthma are shared with diseases of other systems. Features of an airway disorder in adults such as cough, wheeze and breathlessness should be corroborated where possible by measurement of airflow limitation and reversibility. Obstructive airways disease produces a decrease in peak expiratory flow (PEF) and forced expiratory volume in one second (FEV<sub>1</sub>) but which persist after bronchodilators have been administered. One or both of these should be measured, but may be normal if the measurement is made between episodes of bronchospasm. If repeatedly normal in the presence of symptoms, then a diagnosis of asthma must be in doubt.

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

## Children

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

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

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

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

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

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

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

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

## **Asthma 1.2 Reporting and verification**

### **Asthma 1.2.1**

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

### **Asthma 1.2.2**

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

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

## **Asthma indicator 8**

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

### **Asthma 8.1 Rationale**

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

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

Objective measurement of variability either spontaneously over time or in response to therapy is thus fundamental to the diagnosis of asthma and may be conveniently achieved in primary care with serial peak flow measurements. Significant variability in peak flow is defined as a change of 20 per cent or greater with a minimum change of at least 60l/min ideally for three days in a week for two weeks seen over a period of time and may be demonstrated by monitoring diurnal variation, demonstrating an increase after therapy (15 minutes after short-acting bronchodilator, after six weeks inhaled steroids, two weeks oral steroids) or a reduction after exercise or when the



patient next meets their trigger. Spirometry (greater than 15 per cent and 200ml change in FEV<sub>1</sub>) may still be used to confirm variability, though the limitation imposed by a surgery based measurement means that changes over time may be missed.

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

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

## **Asthma 8.2 Reporting and verification**

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

### **Asthma indicator 3**

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

## **Asthma 3.1 Rationale**

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

The number of studies of smoking related to asthma are surprisingly few in number. Starting smoking as a teenager increases the risk of persisting asthma. There are very few studies that have considered the question of whether smoking affects asthma severity. One controlled cohort study suggested that exposure to passive smoke at home delayed recovery from an acute attack. There is also epidemiological evidence that smoking is associated with poor asthma control<sup>(88)</sup>.

It is recommended that smoking cessation be encouraged as it is good for general health and may decrease asthma severity<sup>(89)</sup>.

## **Asthma 3.2 Reporting and verification**

The practice reports the percentage of patients on the asthma register between the ages of 14 and 19 years where smoking status has been recorded in the preceding 15 months.

---

<sup>(88)</sup> See Price et al. Clin Exp Allergy 2005; 35: 282-287.

<sup>(89)</sup> See Price et al. Clin Exp Allergy 2005; 35: 282-287.

## Asthma indicator 6

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

### Asthma 6.1 Rationale

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

National and international guidelines recommend the use of standard questions for the monitoring of asthma. Proactive structured review, as opposed to opportunistic or unscheduled review, is associated with reduced exacerbation rate and days lost from normal activity.

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

"In the last month":

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

Guidelines suggest it should be abnormal in patients with mild to moderate asthma to have any nocturnal waking or activity limitation. Asthma symptoms may be expected on up to three days per week.

If asthma appears to be uncontrolled the following should be examined as part of the asthma review before increasing asthma therapy and treated appropriately:

- smoking behaviour as smoking interferes with asthma control
- poor inhaler technique
- inadequate adherence with regular preventative asthma therapy
- rhinitis

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

Peak flow is a valuable guide to the status of a patient's asthma especially during exacerbations. However, it is much more useful if there is a record of patients' best peak flow, i.e. their peak flow when they are well. Many guidelines for exacerbations are based on the ratio of current to best peak flows. For patients over the age of 18 years there need be no particular time limit on when the best peak flow was measured although in view of the reduction of peak flow with age it is recommended that the

measurement be within the preceding five years. For patients aged 18 years and under the peak flow will be changing; therefore it is recommended that the best peak flow should be re-assessed annually.

Inhaler technique should be reviewed regularly. National and international guidelines emphasise the importance of assessing ability to use inhalers before prescribing, and regularly reviewing technique, especially if control is inadequate. Prescribe inhalers only after patients have received training in the use of the device and have demonstrated satisfactory technique. Reassess inhaler technique as part of structured clinical review.

See SIGN guideline 101 (SIGN and BTS) British Guideline on the Management of Asthma 2008

Summary of Asthma Review:

- assess symptoms (using RCP 3 questions)
- measure peak flow
- assess inhaler technique
- consider personalised asthma plan.

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

## **Asthma 6.2 Reporting and verification**

The practice reports the percentage of patients on their asthma register who have had an asthma review in the preceding 15 months.

Verification – may require randomly selecting a number of case records of patients in which the review has been recorded as taking place in order to confirm that the four elements have been addressed.

## Dementia

Indicator	Points	Payment stages
<b>Records</b>		
DEM1. The practice can produce a register of patients diagnosed with dementia	5	
<b>Ongoing management</b>		
DEM2. The percentage of patients diagnosed with dementia whose care has been reviewed in the preceding 15 months	15	25-60%
DEM3. The percentage of patient with a new diagnosis of dementia (from 1 April 2011) with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded 6 months before or after entering on to the register NICE menu ID: NM09	6	40-80%

### Dementia - rationale for inclusion of indicator set

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

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

### Dementia (DEM) indicator 1

The practice can produce a register of patients diagnosed with dementia.

### Dementia 1.1 Rationale

A register is a pre-requisite for the organisation of good primary care for a particular patient group. There is little evidence to support screening for dementia and it is expected that the diagnosis will largely be recorded from correspondence when

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

## **Dementia 1.2 Reporting and verification**

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

## **Dementia (DEM) indicator 2**

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

## **Dementia 2.1 Rationale**

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

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

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

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

Depression should also be considered since it is more common in people with dementia than those without <sup>(90)</sup>.

Further information

The Audit Commission Report (2002). *Forget Me Not*. <http://www.audit-commission.gov.uk/nationalstudies/health/mentalhealth/Pages/forgetmenot2002.aspx>

The NSF for Older People.

[http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH\\_4003066](http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_4003066)

---

<sup>(90)</sup> Burt et al. *Psychol Bull* 1995; 117: 285-305

Both recommend that patients and carers should be given relevant information about the diagnosis and sources of help and support (bearing in mind issues of confidentiality). Evidence suggests that healthcare professionals can improve satisfaction for carers by acknowledging and dealing with their distress and providing more information on dementia<sup>(91)</sup>. As the illness progresses, needs may change and the review may focus more on issues such as respite care.

There is good evidence from well-designed cohort studies and case control studies of the benefit of healthcare professionals asking about the impact of caring for a person with dementia and the effect this has on the caregiver. It is important to remember that male carers are less likely to complain spontaneously and that the impact of caring is dependent not on the severity of the cognitive impairment but on the presentation of the dementia, for example, on factors such as behaviour and affect. If the carer is not registered at the practice, but the GP is concerned about issues raised in the consultation, then with appropriate permissions, they should contact the carer's own GP for further support and treatment<sup>(92)</sup>.

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

#### Further information

NICE clinical guideline 42 (2006). Dementia. Supporting people with dementia and their carers in health and social care.  
<http://guidance.nice.org.uk/CG42/NICEGuidance/pdf/English>

No decision has been taken on the endorsement of clinical guideline 42 in Northern Ireland but the position is under review. Information on NICE guidance endorsed in NI may be found at: <http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-guidance/sqsd-guidance-nice-guidance.htm>

NICE public health guidance 16 (2008). Mental wellbeing in older people.  
<http://guidance.nice.org.uk/PH16/NICEGuidance/pdf/English>

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

Coping with Dementia – a Handbook for Carers (2008).  
<http://www.healthscotland.com/uploads/documents/7632-CopingWithDementia2008.pdf>

## Dementia 2.2 Reporting and verification

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

---

<sup>(91)</sup> Eccles et al. *BMJ* 1998; 317: 802-808.

<sup>(92)</sup> See Eccles et al. *BMJ* 1998; 317: 802-808.

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

### **Dementia (DEM) 3 (NICE menu NM03)**

The percentage of patients with a new diagnosis of dementia (from 1 April 2011) with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded 6 months before or after entering on to the register.

### **Dementia 3.1 Rationale**

There is no universal consensus on the appropriate diagnostic tests that should be undertaken in those with suspected dementia. However, a review of 14 guidelines and consensus statements found considerable similarity in recommendations<sup>(93)</sup>. The main reason for undertaking investigations in a person with suspected dementia is to exclude a potentially reversible or modifying cause for the dementia and to help exclude other diagnoses (e.g. delirium). Reversible or modifying causes include metabolic and endocrine abnormalities (e.g. vitamin B12 and folate deficiency, hypothyroidism, diabetes and disorders of calcium metabolism).

However, it should be noted that in recent studies the prevalence of reversible dementias was found to be low. Thirty nine studies were reviewed including over 7,000 cases of dementia, and found potentially reversible causes in nine per cent though dementia was actually reversed in only 0.6 per cent of cases<sup>(94)</sup>.

The NICE clinical guideline on dementia<sup>(95)</sup> states that a basic dementia screen should be performed at the time of presentation, usually within primary care. It should include:

- routine haematology
- biochemistry tests (including electrolytes, calcium, glucose, and renal and liver function)
- thyroid function tests
- serum vitamin B12 and folate levels.

### **Dementia 3.2 Reporting and verification**

The practice reports the percentage of patients on the dementia register diagnosed from 1 April 2011 who have had tests for FBC, calcium, glucose, renal, liver and thyroid function, and have serum vitamin B12 and folate levels, recorded up to six months before or six months after entering on to the register.

---

<sup>(93)</sup> Beck C, Cody M, Souder E et al. (2000) Dementia diagnostic guidelines: methodologies, results, and implementation costs. *Journal of the American Geriatrics Society* 48: 1195–1203.

<sup>(94)</sup> Clarfield AM (2003) The decreasing prevalence of reversible dementias: an updated meta-analysis. *Archives of Internal Medicine* 163: 2219–2229.

<sup>(95)</sup> NICE clinical guideline 42 (2006). Dementia. Supporting people with dementia and their carers in health and social care. [www.nice.org.uk/CG42](http://www.nice.org.uk/CG42).

## Depression

Indicator	Points	Payment stages
<b>Diagnosis and initial management</b>		
DEP1. The percentage of patients on the diabetes register and /or the CHD register for whom case finding for depression has been undertaken on one occasion during the preceding 15 months using two standard screening questions	6	40-90%
DEP4. In those patients with a new diagnosis of depression, recorded between the preceding 1 April to 31 March, the percentage of patients who have had an assessment of severity at the time of diagnosis using an assessment tool validated for use in primary care NICE menu ID: NM10	17	40-90%
DEP5. In those patients with a new diagnosis of depression and assessment of severity recorded between the preceding 1 April to 31 March, the percentage of patients who have had a further assessment of severity 4 - 12 weeks (inclusive) after the initial recording of the assessment of severity. Both assessments should be completed using an assessment tool validated for use in primary care NICE menu ID: NM11	8	40-80%

### Depression – rationale for inclusion of the indicator set

Depression is common and disabling.

In 2000, the estimated point prevalence for a depressive episode among 16 - 74 year olds in the UK was 2.6 per cent (males 2.3 per cent, females 2.8 per cent). If the broader and less specific category of ‘mixed depression and anxiety’ is included, these figures increase dramatically to 11.4 per cent (males 9.1 per cent, females 13.6 per cent<sup>(96)</sup>). It contributes 12 per cent of the total burden of non-fatal global disease and by 2020, looks set to be second after CVD in terms of the world’s disabling diseases<sup>(97)</sup>. Major depressive disorder is increasingly seen as chronic and relapsing, resulting in high levels of personal disability, lost quality of life for patients, their family and carers, multiple morbidity, suicide, higher levels of service use and many associated economic costs. In 2000, 109.7 million lost working days and 2615 deaths were attributable to depression. The total annual cost of adult depression in England has been estimated at over £9 billion, of which £370 million represents direct treatment costs.

<sup>(96)</sup> NICE clinical guideline 90 (2009). The treatment and management of depression in adults. <http://guidance.nice.org.uk/CG90>

<sup>(97)</sup> Murray CJL and Lopez AD. *The global burden of disease*. Boston, Mass: WHO and Harvard University Press, 1996.



## Depression (DEP) indicator 1

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

### Depression 1.1 Rationale

Depression is more common in people with CHD and presence of depression is associated with poorer outcomes. Up to 33 per cent of patients develop depression after a myocardial infarction<sup>(98)</sup>.

The presence of depression in people with CHD is associated with reduced compliance with treatment, increased use of health resources, increased social isolation and poorer outcomes<sup>(99)</sup>.

A meta-analysis of 20 trials<sup>(100)</sup> found that depressive symptoms and clinical depression in people with CHD increased mortality for all follow-up periods even after adjustment for other risk factors. In other words, depression was an independent risk factor for mortality in people with CHD. There is Grade A evidence from two randomised controlled trials that (selective serotonin reuptake inhibitors) SSRI antidepressant treatment in people with CHD is safe and effective in reducing depression, at least among those with a prior history of depression and more severe symptoms<sup>(101)</sup>. Patients treated with an SSRI were also found to have a 42 per cent reduction in death or recurrent MI in a sub-group analysis of outcomes in a trial of cognitive behavioural therapy (CBT), although this was a post-hoc observation, and assignment to antidepressants was not randomised<sup>(102)</sup>.

There is a 24 per cent lifetime prevalence of co-morbid depression in individuals with diabetes mellitus<sup>(103)</sup> a prevalence rate three times higher than the general population. A recent meta-analysis of 42 studies found that depression is clinically relevant in nearly one in three patients with diabetes<sup>(104)</sup>. People with both diabetes and depression are less physically and socially active<sup>(105)</sup> and less likely to comply with diet and treatment than people with diabetes alone, leading to worse long term complications and higher mortality. It may also be that practitioners provide poorer care to patients with co-morbid depression and diabetes because depression impairs communication with patients<sup>(106)</sup>. There is good evidence from five randomised controlled trials that effective treatment with either antidepressants or CBT improves the outcome of depression in patients with diabetes<sup>(107)</sup>. While treatment has not

---

<sup>(98)</sup> Davies et al. *BMJ* 2004; 328: 939-943.

<sup>(99)</sup> Carney et al, *American Journal of Cardiology* 2003;92(11): 1277-81.

<sup>(100)</sup> Barth et al. *Psychosomatic Medicine* 2004; 66: 802-13.

<sup>(101)</sup> Glassman et al. *Journal of the American Medical Association* 2002; 288: 701-709; Taylor et al. *Archives of General Psychiatry* 2005; 62: 792-798.

<sup>(102)</sup> Lesperance et al. *Journal of the American Medical Association* 2007; 297: 367-379.

<sup>(103)</sup> Goldney et al. *Diabetes Care* 2004; 27(5): 1066-70.

<sup>(104)</sup> Anderson et al. *Diabetics Care* 2001; 24: 1069-78.

<sup>(105)</sup> Von Korf et al. *Psychosomatic Medicine* 2005; 67: 233-40.

<sup>(106)</sup> Piette et al. *American Journal of Managed Care* 2004; 10: 152-162.

<sup>(107)</sup> Lustman et al. *Psychosomatic Medicine* 1997; 59: 241-50; Lustman et al. *Annals of Internal Medicine* 1998; 129: 613-621; Lustman et al. *Diabetes Care* 2000; 23: 618-23; Katon et al. *Archives of*

been shown consistently to improve glycaemic control, psychological well-being has been identified as an important goal of diabetes management in its own right by the St Vincent Declaration.

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

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

A “yes” answer to either question is considered a positive test. A “no” response to both questions makes depression highly unlikely. These two brief questions could be asked as part of a diabetes or CHD review and patients who answer “yes” to either questions could be referred to the GP for further assessment of other symptoms such as tiredness, guilt, poor concentration, change in sleep pattern and appetite and suicidal ideation to confirm a diagnosis of depression. This assessment should be informed by using a questionnaire measure of severity such as the PHQ-9, HADS, or BDI, as used for the DEP4 indicator (<sup>108</sup>).

The specificity of screening has been shown to be improved by the addition of a third ‘help’ question asked of patients answering ‘yes’ to either of the first two questions: Is this something with which you would like help? (<sup>109</sup>). This third question has three possible responses: ‘no’, ‘yes, but not today’, or ‘yes’. A ‘no’ response to this third question makes major depression highly unlikely (negative predictive value (NPV) of 94 per cent). It is important to stress therefore that a negative result to the two to three item screen can usually be taken to indicate that the patient doesn’t have depression.

## Depression 1.2 Reporting and verification

The practice reports the percentage of patients on their diabetes and CHD registers whose records show that they have been screened for depression using the two standard questions. This screening will have been recorded in the preceding 15 months. These questions should be asked as part of a consultation and should not be posted to patients.

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

## Depression (DEP) Indicator 4 (NICE menu NM10)

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

---

*General Psychiatry* 2004; 61: 1042-49; Williams et al. *Annals of Internal Medicine* 2004; 140: 1015-24..

(<sup>108</sup>) see also Whooley et al. *Journal of General Internal Medicine* 1997; 12 (7): 439-45.

(<sup>109</sup>) Arroll et al. *British Medical Journal* 2005; doi:10.1136/bmj.38607.464537.7c.

severity at the time of diagnosis using an assessment tool validated for use in primary care.

## Depression 4.1 Rationale

This indicator applies to adults aged 18 years and over with a new diagnosis of depression in the preceding 1 April to 31 March. This indicator does not include women with postnatal depression.

Assessment of severity in patients with depression is essential to decide on appropriate interventions and improve the quality of care. An assessment of severity as close as possible to the time of diagnosis enables a discussion with the patient about relevant treatment and options, guided by the stepped care model of depression described in the NICE clinical guideline 90. The guideline states, for example, that antidepressants are not recommended for the initial treatment of mild depression but should be routinely considered for all patients with moderate or severe depression. The British Association of Psychopharmacology guideline on treating depressive disorders with antidepressants state ‘that antidepressants are a first-line treatment for moderate to severe major depression irrespective of environmental factors and that antidepressants are not indicated for milder depression unless it has persisted for two years or more’ (‘dysthymia’) <sup>(110)</sup>.

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

### Patient Health Questionnaire

The PHQ-9 is a nine-question self-report measure of severity that takes approximately three minutes to complete. It uses the ‘Diagnostic and Statistical Manual of Mental Disorders, fourth edition’ (DSM-IV) criteria for depression and scores are categorised as minimal (1 – 4), mild (5 – 9), moderate (10 – 14), moderately severe (15 – 19) and severe depression (20 – 27). It was developed and validated in the United States and can be downloaded free of charge: <http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/>

### Hospital Anxiety and Depression Scale

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

---

<sup>(110)</sup> Anderson IM, Ferrier IN, Baldwin RC et al. (2008) Evidence-based guidelines for treating depressive disorders with antidepressants: a revision of the 2000 BAP guidelines. *Journal of Psychopharmacology* 22: 343–96. [www.bap.org.uk/pdfs/antidepressants.pdf](http://www.bap.org.uk/pdfs/antidepressants.pdf)

The HADS allows the severity of both anxiety and depression to be established simultaneously. Separate scores are given for anxiety and depression, which are independent measures. The HADS can be ordered from:

<http://shop.gla-assessment.co.uk/home.php?cat=417&gclid=CPPr3fjJhpkCFQ6wQwodI2Krlw>

The HADS depression subscale (HAD-D) has 90 per cent sensitivity and 86 per cent specificity for depression compared to the gold standard of a structured diagnostic interview<sup>(111)</sup>,<sup>(112)</sup>.

Beck Depression Inventory, second edition

The BDI-II is a 21 item self-report instrument that uses DSM-IV criteria. It takes approximately five minutes to complete. A total score of 0 – 13 is considered minimal range, 14 – 19 is mild, 20 – 28 is moderate, and 29 – 63 is severe. The instruments and manuals can be ordered online from: [www.pearson-uk.com/product.aspx?n=1316&s=1322&cat=1426&skey=2646&gclid=Cluxq5CioZMCFQ6KMAodj16TrQ](http://www.pearson-uk.com/product.aspx?n=1316&s=1322&cat=1426&skey=2646&gclid=Cluxq5CioZMCFQ6KMAodj16TrQ)

Not all severity assessment measures map directly onto NICE guidance, which uses ICD-10 symptoms in defining mild, moderate, severe and severe depression with psychotic symptoms. However, the underlying principle of all three suggested measures is that a higher score indicates greater severity requiring different types of intervention.

Recent research has shown that the use of severity measures is valued by patients and that doctors' intervention and referral rates are related to the scores on the measures. Qualitative interviews with patients who had been assessed with the measures revealed that they saw them as evidence that GPs were carrying out a full assessment which helped them to receive intervention in line with the severity of their depression. The measures also helped some patients to understand how their different symptoms made sense when considered together as the syndrome of depression<sup>(113)</sup>.

Prior to the introduction of the questionnaire measures into the QOF, an audit was carried out of the use of the HAD-D by volunteer GPs in Southampton. The likelihood of being prescribed an antidepressant increased significantly with severity on the HAD-D measure and was associated with improved targeting of antidepressant treatment when compared to a study carried out in the same area prior to the introduction of the HAD-D measure<sup>(114)</sup>.

A more recent analysis of the use of the two most commonly used measures (the PHQ-9 and HAD-D) in 38 practices in three centres also found that rates of intervention and referral increased in line with higher scores. However, it was found that overall rates of intervention and referral were very similar for patients assessed with either measure, despite the fact that the PHQ-9 classified significantly more patients as moderately to severely depressed and in need of intervention, compared to

<sup>(111)</sup> Zigmond AS, Snaith RP (1983) The hospital anxiety and depression scale. *Acta Psychiatr Scand* 67: 361–70.

<sup>(112)</sup> Wilkinson MJ, Barczak P (1988) Psychiatric screening in general practice: comparison of the general health questionnaire and the hospital anxiety depression scale. *Journal of the RCGP* 38: 311–3.

<sup>(113)</sup> Dowrick C, Leydon GM, McBride A et al. (2009) Patients' and doctors' views on depression severity questionnaires incentivised in UK the QOF: qualitative study. *BMJ* 19: 338.

<sup>(114)</sup> Kendrick T, King F, Albertella L et al. (2005) GP treatment decisions for patients with depression. *British Journal of General Practice* 55: 280–6.

the HAD-D. These results suggest practitioners do not decide on drug treatment or referral on the basis of the severity questionnaire scores alone <sup>(115)</sup>. They also suggest that the two most commonly used measures are inconsistent, the PHQ-9 rating more people above the recommended threshold for intervention than the HAD-D. This is consistent with other new evidence suggesting the thresholds for intervention for these instruments should be revised.

#### Revised thresholds for intervention

A study in which the PHQ-9 and HAD-D were administered together to a single sample of patients also found that a greater proportion of the sample was classified as depressed according to the PHQ-9 compared with the HAD-D <sup>(116)</sup>. Validation studies against more extensive ‘gold standard’ diagnostic assessments have suggested that the validity of the measures in terms of identifying major depressive disorder could be improved by using a more conservative cut-off score of 12 rather than ten on the PHQ-9 and a less conservative cut-off of ten rather than 11 on the HAD-D <sup>(117)</sup>, <sup>(118)</sup>. Changing the recommended threshold scores for intervention would therefore make these measures more valid against longer assessments, more consistent with each other, and more consistent with practitioners’ clinical judgment.

The revised recommended thresholds for considering intervention are therefore:

- PHQ-9 score: 12
- HAD-D score: 10
- BDI-II score: 20

However, it is important to stress that symptom scores alone should not be used to determine the presence of depression which needs treatment.

It is also important for clinicians to consider family and previous history as well as the degree of associated disability and patient preference in making an assessment of the need for treatment, rather than relying completely on a single symptom count at one point in time.

Decisions about treatment and referral should take into account the:

- severity of symptoms (assessed clinically as well as with a measure)
- functional impairment (significant effects on work and daily activities)
- duration (watchful waiting for around eight weeks for mild symptoms)
- course (trajectory of scores, past history).

In addition, the PHQ-9 and the BDI-II have not been validated in terms of their cultural sensitivity and it is important to bear this in mind if using them with black and minority ethnic populations.

---

<sup>(115)</sup> Kendrick T, et al. *BMJ*, in press.

<sup>(116)</sup> Cameron I, Crawford J, Lawton K et al. (2008) Psychometric comparison of PHQ-9 and HADS for measuring depression severity in primary care. *British Journal of General Practice* 58: 32–6.

<sup>(117)</sup> Löwe B, Spitzer RL, Gräfe K et al. (2004) Comparative validity of three screening questionnaires for DSM-IV depressive disorders and physicians' diagnoses. *J Affect Disord* 78: 131–40.

<sup>(118)</sup> Gilbody S, Richards D, Barkham M (2007) Diagnosing depression in primary care using self-completed instruments: UK validation of PHQ-9 and CORE-OM. *British Journal of General Practice* 57: 650–2

## Depression 4.2 Reporting and verification

The practice reports the percentage of patients with a new diagnosis of depression whose notes record that they have had an assessment of severity at the time of diagnosis, defined as within 28 days of the initial diagnosis. New diagnoses are those which have been made between the preceding 1 April to 31 March. The practice should also report in each patient record which of the three assessment tools they used.

Verification – may require randomly selecting a number of case records of patients with a new diagnosis of depression to verify that their notes record an assessment of severity.

### Timeframe

The original DEP2 indicator was introduced to QOF in April 2006. From April 2009 the associated business rules were revised to deal with a cross-year indicator where workload spans more than one QOF year, to:

- ensure fair and consistent payments to all practices
- ensure that patients who were diagnosed in the last three months of the QOF year are identified

The QOF is set up to support annual activity that is completed in one QOF calendar year, which runs from 1 April to 31 March. Prior to the business rule change in April 2009, any patient newly diagnosed with depression between January and February would have been removed from the denominator, due to the new diagnosis exception criteria. Furthermore, because the indicator specifically relates to a new diagnosis, the same patient would not be picked up in the following QOF year.

The depression indicator business rules were therefore revised, from 1 April 2009, to cover 15 months so as to address this issue.

DEP2 was reviewed and updated through the NICE process and replaced by DEP4 in April 2011. The above explanation for the timeframe and the business rules still applies.

## Depression (DEP) indicator 5 (NICE menu NM11)

In those patients with a new diagnosis of depression and assessment of severity recorded between the preceding 1 April to 31 March, the percentage of patients who have had a further assessment of severity 4 - 12 weeks (inclusive) after the initial recording of the assessment of severity. Both assessments should be completed using an assessment tool validated for use in primary care.

## Depression 5.1 Rationale

The rationale for such follow-up measurement is derived from the recognition that depression is often a chronic disease, yet treatment is often episodic and short-lived<sup>(119)</sup>.

---

<sup>(119)</sup> Kates N, Mach M (2007) Chronic disease management for depression in primary care: a summary of the current literature and implications for practice. *Canadian Journal of Psychiatry* 52: 77-85.

The change to the wording of this indicator, from 5 – 12 weeks to 4 – 12 weeks, recognises that in clinical practice most prescriptions or follow-up appointments are given for one, two or four weeks at this stage in the illness.

If treatment with antidepressants is initiated, patients should be followed-up regularly for several months. The NICE clinical guideline 90 recommends that ‘for people started on antidepressants who are not considered to be at increased risk of suicide, normally see them after two weeks. See them regularly thereafter, for example at intervals of two to four weeks in the first three months and then at longer intervals if the response is good.’ Early cessation of treatment is associated with a greater risk of relapse.

The guideline also suggests that a person who has benefited from taking an antidepressant should continue medication for at least six months after remission of an episode of depression. However, one study showed that only up to one-third of patients prescribed antidepressants were still receiving medication at four to six months (<sup>120</sup>).

Analysis of the GP Research Database for the years 1993 to 2005 has confirmed this finding: more than half of patients treated with antidepressants for a new diagnosis of depression during those years received prescriptions for only one or two months of treatment, and that this pattern had not changed over the 13 year period (<sup>121</sup>).

If drug treatment is not started after the initial diagnosis, patients should in any case be reassessed to see whether their symptoms have resolved or worsened to the point where treatment becomes advisable.

Recent research into the use of severity measures has shown that patients whose GPs used the measures for follow-up in addition to initial assessment valued having repeated scores to help monitor their progress and assess the effectiveness of treatment (<sup>122</sup>). Most of the GPs interviewed for the same study believed that there was value in repeating the score as a way of monitoring patients’ progress.

The nine item Patient Health Questionnaire (PHQ-9) has been shown to be a responsive and reliable measure for gauging response to treatment in individual patient care (<sup>123</sup>).

## Depression 5.2 Reporting and verification

The practice reports the percentage of patients with a new diagnosis of depression whose notes record that they have had an assessment of severity 4 - 12 weeks (inclusive) after the initial recording of the assessment of severity related to a new diagnosis of depression. New diagnoses are those which have been made between the preceding 1 April to 31 March. To be included in the numerator for this indicator a patient needs to have had both an initial and a subsequent severity assessment.

---

(<sup>120</sup>) Donoghue J (2000) Antidepressant use patterns in clinical practices: comparisons among tricyclic antidepressants and selective serotonin reuptake inhibitors. *Acta Psychiatrica Scandinavica* 101: (suppl 403): 57–61.

(<sup>121</sup>) Moore M, Yuen HM, Dunn N et al. (2009) Explaining the rise in antidepressant prescribing: a descriptive study using the GPRD. *BMJ* 339: b3999.

(<sup>122</sup>) Dowrick C, Leydon GM, McBride A et al. (2009) Patients’ and doctors’ views on depression severity questionnaires incentivised in the UK QOF: qualitative study. *BMJ* 338: b6636.

(<sup>123</sup>) Löwe B, Unützer J, Callahan CM et al. (2004) Monitoring depression treatment outcomes with the PHQ-9. *Medical Care* 42: 1194-1201.

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

Verification - may require randomly selecting a number of case records of patients with a new diagnosis of depression to verify that their notes record a follow-up assessment of severity 4 – 12 weeks after the initial assessment of severity.

#### Timeframe

The DEP3 indicator was introduced to QOF in April 2009 and for that reason, the first line of the supporting business rules excluded patients newly diagnosed before April 2009. The business rules for DEP3, like DEP2 (now DEP4), were structured to take account of the cross-year issue which ensures fair and consistent payment to practices and good patient care. The business rules therefore look back 68 weeks to address this issue.

DEP3 was reviewed and updated through the NICE process and replaced by DEP5 in April 2011. The above explanation for the timeframe and the business rules still applies.



## Chronic kidney disease (CKD)

Indicator	Points	Payment stages
<b>Records</b>		
CKD1. The practice can produce a register of patients aged 18 years and over with CKD (US National Kidney Foundation: Stage 3 to 5 CKD)	6	
<b>Initial management</b>		
CKD2. The percentage of patients on the CKD register whose notes have a record of blood pressure in the preceding 15 months	6	40-90%
<b>Ongoing management</b>		
CKD3. The percentage of patients on the CKD register in whom the last blood pressure reading, measured in the preceding 15 months, is 140/85 or less	11	40-70%
CKD5. The percentage of patients on the CKD register with hypertension and proteinuria who are treated with an angiotensin converting enzyme inhibitor (ACE-I) or angiotensin receptor blocker (ARB) (unless a contraindication or side-effects are recorded)	9	40-80%
CKD6. The percentage of patients on the CKD register whose notes have a record of a urine albumin: creatinine ratio (or protein:creatinine ratio) test in the preceding 15 months	6	40-80%

### Chronic kidney disease – rationale for inclusion of indicator set

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

CKD is a long term condition; the most recent population data from the National Health and Nutrition Examination Survey (NHANES 1999-2004) suggests that the age standardised prevalence of stage 3 to 5 CKD in the non-institutionalised American population is approximately six per cent<sup>(124)</sup>. The prevalence in females was higher than in males (6.9 per cent versus 4.9 per cent). In the fully adjusted model, the

<sup>(124)</sup> Coresh et al *JAMA*. 2007;298(17):2038-2047.

prevalence of low GFR was strongly associated with diagnosed diabetes (OR, 1.54; 95% CI, 1.28-1.80) and hypertension (OR, 1.98; 95%CI, 1.73-2.67) as well as higher BMI (OR, 1.08; 95% CI, 1.02-1.15 per 5-unit increment of BMI).

In the UK the prevalence of CKD stage 3–5 was 8.5 per cent and was higher in females, 10.6 per cent in females versus 5.8 per cent in males <sup>(125)</sup>. The Association of Public Health Observatories (APHO) has modelled the prevalence of CKD for England and Wales based on the results of the study by Stevens et al and report a population prevalence of 8.9 per cent:

<http://www.apho.org.uk/resource/item.aspx?RID=65647>

<http://www.apho.org.uk/resource/item.aspx?RID=63798>

The NHS Information Centre reports a prevalence of CKD for 2009/10 of 4.3 per cent using QMAS returns suggesting that, to date, CKD is under-reported in English GP practices.

**Table 4: Estimated glomerular filtration rate (eGFR) to measure kidney function**

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

\* All GFR values are normalized to an average surface area (size) of 1.73m<sup>2</sup>

#### Further information

National service framework for Renal Services (2005).  
<http://www.kidney.org.uk/campaigns/Renal-nsf/nsf-pt2.pdf>

This indicator set applies to people with stage three, four and five CKD (eGFR <60mL/min/1.73m<sup>2</sup> confirmed with at least two separate readings over a three month period).

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

<sup>(125)</sup> Stevens et al. *Kidney International* 2007; 72: 92-9.

Only a minority of people with stage one or two CKD go on to develop more advanced disease and symptoms do not usually appear until stage four. Where eGFR has persistently been recorded below 60 (<60) the CKD (stage 3) label should continue to apply, even if future management may lead to an improvement in eGFR.

Early identification of CKD is important as it allows appropriate measures to be taken not only to slow or prevent the progression to more serious CKD but also to combat the major risk of illness or death due to cardiovascular disease. The presence of proteinuria is a key risk multiplier at all stages of CKD and CKD is an independent risk factor for CVD and a multiplier of other risk factors (<sup>126</sup>).

Further information

[NICE clinical guideline 73 \(2008\). Early identification and management of CKD in adults in primary and secondary care. http://www.nice.org.uk/CG73](http://www.nice.org.uk/CG73)

[SIGN clinical guideline 103 \(2008\). Diagnosis and management of CKD in adults. http://www.sign.ac.uk/guidelines/fulltext/103/index.html](http://www.sign.ac.uk/guidelines/fulltext/103/index.html)

These indicators reflect both of the guidance documents:

- Albumin:creatinine ratio (ACR) is the preferred measure of proteinuria
- NICE suggests BP should be kept below 140 (systolic) and 90 (diastolic) with a target for systolic of between 120 and 139 mmHg. There is a tougher standard for diabetes. This compares with a BP audit standard of 145/85 in this guidance for 40 to 70 per cent of the CKD population
- NICE recommends that the use of ACE-I when there is hypertension and an ACR of  $\geq 30$ mg/mmol. However, when ACR  $\geq 70$ mg/mmol NICE recommends ACE-I even in the absence of hypertension. As with BP there are stricter standards in diabetes
- NICE divides stage three into stage 3a and 3b. They recommend testing for bone disease and anaemia in stage 3b (eGFR 30 to 44), as well as stages four and five
- NICE also recommends addition of the suffix (p) to denote significant proteinuria, defined as an ACR  $\geq 30$  mg/mmol (PCR  $\geq 50$  mg/mmol)

The QOF indicators are likely to converge with NICE guidance over coming years.

## **Chronic kidney disease (CKD) indicator 1**

The practice can produce a register of patients aged 18 years and over with CKD (US National Kidney Foundation: Stage 3 to 5 CKD).

### **Chronic kidney disease 1.1 Rationale**

Patients aged 18 years and over with a persistent estimated GFR or GFR of  $<60$ ml/min/1.73m<sup>2</sup> should be included in the register. From 2006, eGFR has been reported automatically when serum creatinine concentration is measured. Studies of

---

(<sup>126</sup>) Wali and Henrich. *Cardiol Clin* 2005; 23(3): 343-62.

general practice computerised medical records show that it is feasible to identify people with CKD (<sup>127</sup>) and that computer records are a valid source of data (<sup>128</sup>).

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

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

## **Chronic kidney disease 1.2 Reporting and verification**

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

## **Chronic kidney disease (CKD) indicator 2**

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

## **Chronic kidney disease 2.1 Rationale**

Studies show that reducing blood pressure in people with CKD reduces the rate of deterioration of their kidney function whether or not they have hypertension or diabetes (<sup>129</sup>).

## **Chronic kidney disease 2.2 Reporting and verification**

The practice reports the percentage of patients on its CKD register who have had a blood pressure measurement recorded in the preceding 15 months.

## **Chronic kidney disease (CKD) indicator 3**

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

## **Chronic kidney disease 3.1 Rationale**

Studies have shown that in people over 65 years and in people with diabetes, normal blood pressure is hard to achieve but is important (<sup>130</sup>).

See also the BHSOC guidelines 2004 (<sup>131</sup>). This suggests an “optimal” BP target in CKD of 130/80 mmHg or 127/75 mmHg if >1g proteinuria. These targets in turn are derived from the Modification of Diet in Renal Disease study (<sup>132</sup>).

---

<sup>(127)</sup> de Lusignan et al. *Fam Pract* 2005; 22(3): 234-41.

<sup>(128)</sup> Anandarajah et al. *Nephrol Dial Transplant* 2005; 20(10): 2089-96.

<sup>(129)</sup> Jafar et al. *Ann Int Med* 2003; 139: 244-52.

<sup>(130)</sup> Anderson et al. *American Journal of Kidney Disease* 2005; 45(6): 994-1001.

<sup>(131)</sup> Williams et al. *J Human Hypertension* 2004; 18: 139-185 (specific renal advice on pages 166-7).

<sup>(132)</sup> Klar et al. *NEJM* 1994; 330: 877-884; Peterson et al. *Ann Int Med* 1995; 123: 754-762.

In practice, these targets are often hard to achieve and the indicator's 40 per cent to 70 per cent audit standard reflects this. The lower the blood pressure achieved the better for patient care; 140/85 mmHg is used here as an audit standard for this indicator.

Further information

NICE clinical guideline 73 (2008). [CKD](http://www.nice.org.uk/Guidance/CG73) in adults in primary and secondary care. <http://www.nice.org.uk/Guidance/CG73>

SIGN clinical guideline 103 (2008). Diagnosis and management of CKD in adults. <http://www.sign.ac.uk/guidelines/fulltext/103/index.html>

## **Chronic kidney disease 3.2 Reporting and verification**

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

## **Chronic kidney disease (CKD) indicator 5**

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

## **Chronic Kidney Disease 5.1 Rationale**

ACE inhibitors and ARBs are generally more effective than other anti-hypertensives in minimising deterioration in kidney function and this effect is most marked where there is significant proteinuria. Such treatment is both clinically and cost-effective<sup>(133)</sup>.

The gold standard test for measuring proteinuria is a 24 hour urine collection; though problems with timing and completeness make this an impractical test to use in general practice. The alternatives are to test the albumin-creatinine ratio (ACR) or protein:creatinine ratio (PCR) in the urine or to use a stick test.

SIGN guidance also recommends measuring proteinuria with ACR in patients with diabetes and TPCR in non-diabetic patients, reflecting the differing evidence base for these two patient populations whereas recent NICE guidance has suggested that the ACR should be used in all patients.

Further information

NICE clinical guideline 73 (2008). CKD in adults in primary and secondary care.

SIGN clinical guideline 103 (2008). Diagnosis and management of CKD in adults.

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

---

<sup>(133)</sup> Kent et al JASN 2007;18:1959-1965. See also: Lewis et al. NEJM 1993; 329:1456-1462; Brenner et al. NEJM 2001; 345:861-869; Ruggenenti et al. Lancet 1999; 354: 359-364.

A systematic review has shown that investigation for infection of asymptomatic people with one “+” or more of is not indicated (<sup>134</sup>). Practitioners should only go on to send off a mid-stream urine or perform another test to look for infection if there are symptoms.

It is not possible to derive a simple correction factor that allows the conversion of ACR values to PCR or 24 hour urinary protein excretion rates because the relative amounts of albumin and other proteins will vary depending on the clinical circumstances; however, the following table of approximate equivalents will allow clinicians unfamiliar with ACR values to see the approximate equivalent PCR and 24 hour urinary protein excretion rates (see table 5).

**Table 5: Approximate equivalent ACR, PCR and 24 hour urinary protein excretion**

Albumin:creatinine ratio (mg/mmol)	Protein:creatinine ratio (mg/mmol)	24 hour urinary protein excretion (g/day)
30	50	0.5
70	100	1

## Chronic kidney disease 5.2 Reporting and verification

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

## Chronic kidney disease (CKD) indicator 6

The percentage of patients on the CKD register whose notes have a record of a urine albumin:creatinine ratio (or protein:creatinine ratio) test in the preceding 15 months.

## Chronic kidney disease 6.1 Rationale

Quantitative measurement of proteinuria will enable appropriate management of patients with CKD. There is good observational evidence linking proteinuria to adverse outcome (<sup>135</sup>).

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

SIGN recommends the use of ACE-1 and/or ARBs as agents of choice in patients with proteinuria  $>0.5$ g/day (approximately equivalent to a PCR of  $>50$ mg/mmol).

<sup>(134)</sup> Carter JL et al Nephrol Dial Transplant. 2006 Nov; 21(11):3031-7.

<sup>(135)</sup> Foster M. Arch Intern Med. 2007; 167(13):1386–92. Hallan S. Arch Intern Med. 2007; 167(22):2490–2496. Cirillo M. Arch Intern Med. 2008; 168(6):617–24. Brantsma A, J. Am Soc Nephrol. 2008; 19(9):1785-91.

As with BP there are stricter standards for those with diabetes; ACR >2.5mg/mmol in men and >3.5mg/mmol in women – with or without hypertension.

## **Chronic kidney disease 6.2 Reporting and verification**

The practice reports the percentage of patients on its CKD register who have an ACR or PCR test recorded in the preceding 15 months.

## Atrial fibrillation

Indicator	Points	Payment stages
<b>Records</b>		
AF1. The practice can produce a register of patients with atrial fibrillation	5	
<b>Initial diagnosis</b>		
AF4. The percentage of patients with atrial fibrillation diagnosed after 1 April 2008 with ECG or specialist confirmed diagnosis	10	40-90%
<b>Ongoing management</b>		
AF3. The percentage of patients with atrial fibrillation who are currently treated with anti-coagulation drug therapy or an anti-platelet therapy	12	40-90%

### Atrial fibrillation - rationale for inclusion of indicator set

Atrial Fibrillation (AF) is common, and an important cause of morbidity and mortality. The age specific prevalence of AF is rising, presumably due to improved survival of people with CHD (the commonest underlying cause of AF<sup>(136)</sup>). One percent of a typical practice population will be in AF; five per cent of over 65s, and nine per cent of over 75 year olds. Atrial fibrillation is associated with a five fold increase in risk of stroke<sup>(137)</sup>.

SIGN clinical guideline 94 (2007). Cardiac Arrhythmias in coronary heart disease.  
[www.sign.ac.uk/guidelines/fulltext/94/index.html](http://www.sign.ac.uk/guidelines/fulltext/94/index.html)

### Atrial fibrillation (AF) indicator 1

The practice can produce a register of patients with atrial fibrillation.

#### AF 1.1 Rationale

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

<sup>(136)</sup> Psaty et al. Circulation 1997; 96: 2455-61.

<sup>(137)</sup> Wolf et al. Stroke 1991; 22: 983-88.



## **AF 1.2 Reporting and verification**

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

### **Atrial fibrillation (AF) indicator 4**

The percentage of patients with atrial fibrillation diagnosed after 1 April 2008 with ECG or specialist confirmed diagnosis.

#### **AF 4.1 Rationale**

AF is historically too often inaccurately coded. Patients with an irregular pulse have been given an AF code even though the accuracy of AF diagnosed in this way is only approximately 30 per cent. The introduction of this indicator will enable the compilation of a more accurate register and help to ensure that treatments are targeted more appropriately. The act of referral for a specialist opinion (e.g. cardiology out patient or ECG technician report) is insufficient to achieve this indicator.

#### **AF 4.2 Reporting and verification**

The practice reports those patients with AF diagnosed after 1 April 2008 who have had an ECG or been diagnosed by a specialist within three months of being added to the register. The practice may also report patients who have been diagnosed or had an ECG up to three months before being added to the register.

### **Atrial fibrillation (AF) indicator 3**

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

#### **AF 3.1 Rationale**

There is strong evidence that stroke risk can be substantially reduced by warfarin (approximately 66 per cent risk reduction) <sup>(138)</sup> and less so by aspirin (approximately 22 per cent risk reduction) <sup>(139)</sup>. Warfarin in particular is under used for stroke prevention in AF. A NICE costing report accompanying the recommendations for AF treatment in 2006 <sup>(140)</sup> estimated that nationally 355,312 patients with AF should be on warfarin (i.e. all of those assessed as high risk, half of those at moderate risk and none of those at low risk, using the NICE stroke risk stratification algorithm and if not contraindicated), or an additional 165,946 patients who were not receiving this treatment – almost 50 per cent of those estimated as requiring warfarin. Therefore there is clearly a need to encourage the use of this treatment for AF patients at high

---

<sup>(138)</sup> AF Investigators. Risk Factors for stroke and efficacy of antithrombotic therapy in AF: analysis of pooled data from five randomized clinical trials. *Arch Intern Med.* 1994; 154: 1949-1957.

<sup>(139)</sup> Antithrombotic Trialists' Collaboration. Collaborative meta-analysis of randomised trials of antiplatelet therapy for prevention of death, myocardial infarction, and stroke in high risk patients. *BMJ.* 2002 Jan 12;324(7329):71-86.

<sup>(140)</sup> AF. The management of AF costing report. NICE 2006.

risk of stroke. Furthermore, recent evidence from the BAFTA trial <sup>(141)</sup> and the ACTIVE-W <sup>(142)</sup> study suggests not only is warfarin much more effective than aspirin, but that it is not as unsafe – in terms of risk of serious haemorrhage - as previously thought (though it would be useful to ascertain if these findings are replicated elsewhere using an appropriate meta-analysis).

Nevertheless, a significant proportion of AF patients – depending on the particular risk stratification scheme selected this can be the majority of people with AF - are not considered to be at high risk of stroke, though clearly this does not mean their risk of stroke is non-existent. Therefore, any treatment indicator (or set of indicators) should not focus solely on the high risk group, if that means the large group considered at moderate risk (or even those at low risk) are then excluded from their treatment being monitored. The NICE AF guidelines <sup>(143)</sup> suggest that for those at moderate risk, ‘anticoagulation or antiplatelet therapy should be prescribed depending upon patient preference after discussion of risks and benefits’. This guidance therefore enables the clinician and patient to decide on the preferred regime, taking risks and benefits of both treatments (i.e. anticoagulant and antiplatelet therapy) into account, for all AF patients, whatever their category of stroke risk.

NICE Grade A evidence.

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

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

### **AF 3.2 Reporting and verification**

The practice reports the percentage of patients with AF whose records show they have been prescribed anti-coagulant or anti-platelet drug therapy in the preceding six months.

---

<sup>(141)</sup> Mant J, Hobbs FDR, Fletcher K, Roalfe A, Fitzmaurice D, Lip GYH, Murray E. Warfarin versus aspirin for stroke prevention in an elderly community population with atrial fibrillation (the Birmingham AF Treatment of the Aged Study, BAFTA): a randomised controlled trial. *Lancet* 2007; 370: 493-503.

<sup>(142)</sup> Healey JS, Hart RG, Pogue J, Pfeffer MA, Hohnloser SH, De Caterina R, Flaker G, Yusuf S, Connolly SJ. Risks and Benefits of Oral Anticoagulation Compared With Clopidogrel Plus Aspirin in Patients With AF According to Stroke Risk: the AF Clopidogrel Trial with Irbesartan for prevention of Vascular Events (ACTIVE – W). *Stroke*. 2008; 39: 1482- 1486.

<sup>(143)</sup> Royal College of Physicians (2006). AF National Clinical Guideline for Management in Primary and Secondary Care. <http://bookshop.rcplondon.ac.uk/details.aspx?e=33>

## Obesity

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

### Rationale for inclusion of indicator set

The prevalence of obesity in the United Kingdom is at least 21 per cent in men and 23.5 per cent in women and looks set to continue to rise <sup>(144)</sup>.

There is a substantive evidence base on the epidemiology of obesity and its association with poor clinical outcomes. In addition to the obvious associated disease burden such as inactivity, degenerative joint disease, lower employment and mood disorders, obesity is also a major contributory factor for some of the commonest causes of death and disability in developed economies, most notably greater rates of diabetes mellitus <sup>(145)</sup> and accelerated onset of cardiovascular disease <sup>(146)</sup>. Obesity has therefore become a major health issue for the United Kingdom. The Foresight UK Tackling Obesities report 2007 estimated the cost to the UK of obesity to be £50 billion in 2050 at today's prices.

<http://www.bis.gov.uk/foresight/our-work/projects/current-projects/tackling-obesities/reports-and-publications>

NICE clinical guideline 43 (2008). Prevention, identification, assessment and management of overweight and obesity in adults and children. <http://www.nice.org.uk/Guidance/CG43>

Tackling obesity is a high priority for the four UK health departments.

In England this is happening through the 'Healthy Weight Healthy Lives <sup>(147)</sup>' strategy and the current Change4Life campaign has a particular focus on at risk families. In Northern Ireland this is happening through the draft *Obesity Prevention Framework for NI 2011-2021 – A fitter Future for All* <sup>(148)</sup>.

In Scotland this is happening through the Scottish Government and COSLA long term obesity strategy, published in February 2010, 'Preventing Overweight and Obesity in Scotland: A Route Map Towards Healthy Weight <sup>(149)</sup>'.

<sup>(144)</sup> Forecasting obesity to 2010, DH, 2006  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH\\_4138630](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_4138630)

<sup>(145)</sup> Sullivan et al. Diabetes Care 2005; 28 (7): 1599-603.

<sup>(146)</sup> Gregg et al. JAMA 2005; 293 (15): 1868-74.

<sup>(147)</sup> <http://www.dh.gov.uk/en/PublicHealth/Healthimprovement/Obesity/index.htm>

<sup>(148)</sup> <http://dhsspsni.gov.uk/show/consultations?txtid=44910>

<sup>(149)</sup> Preventing Overweight and Obesity in Scotland: A Route Map Towards Healthy Weight.  
<http://www.scotland.gov.uk/Publications/2010/02/17140721/0>



The 'Obesity Route Map' recognises that people cannot be expected to change their behaviour alone as the environment we live in today means that for most people weight gain becomes almost inevitable. Excellent work is already being done but the Scottish Government are committed to go further to make changes that will transform our living environment.

In Wales this is happening through the All Wales Obesity Pathway <sup>(150)</sup>, published in June 2010. This is intended for use as a tool for Local Health Boards to map provision for the prevention and treatment of obesity, to identify gaps and to implement and manage activity across the full range of determinants which cause obesity and overweight patients in Wales.

Further information

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

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

## **Obesity (OB) indicator 1**

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

### **OB 1.1 Rationale**

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

### **OB 1.2 Reporting and verification**

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

---

<sup>(150)</sup> All Wales Obesity Pathway. <http://Wales.gov.uk/topics/health/improvement/index/pathway/?lang=en>

## Learning disabilities

Indicator	Points	Payment stages
<b>Records</b>		
LD1. The practice can produce a register of patients aged 18 years and over with learning disabilities	4	
LD2. The percentage of patients on the learning disability register with Down's Syndrome aged 18 years and over who have a record of blood TSH in the preceding 15 months (excluding those who are on the thyroid disease register) NICE menu ID: NM04	3	40-70%

### Rationale for inclusion of indicator set

People with learning disabilities are amongst the most vulnerable and socially excluded in our society. It is estimated that there are approximately 20/1,000 people with mild learning disabilities and 3-4/1000 people with severe and profound learning disabilities in the UK. Over the past three decades, almost all the long stay NHS beds for people with learning disabilities have closed, and virtually all people with learning disabilities are now living in the community and depend on their practice for their primary health care needs.

Further information

Royal College of Nursing learning disabilities guidance.

[http://www.rcn.org.uk/development/practice/social\\_inclusion/learning\\_disabilities/guidance](http://www.rcn.org.uk/development/practice/social_inclusion/learning_disabilities/guidance)

Department of Health (2009). 'Valuing People Now' a new three-year strategy for people with learning disabilities, sets out the Government's strategy for people with learning disabilities for the next three years following consultation.

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_093377](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093377)

'The Same as You?' Scottish Executive (2000).

<http://www.scotland.gov.uk/Topics/Health/care/adult-care-and-support/learning-disability/Resources/sameasyou>

NHS Health Scotland (2004). Health Needs Assessment Report. People with Learning Disabilities. [http://www.healthscotland.com/uploads/documents/LD\\_summary.pdf](http://www.healthscotland.com/uploads/documents/LD_summary.pdf)

Northern Ireland Strategy on Learning Disability.

<http://www.rmhdni.gov.uk/index/published-reports.htm>

Welsh Assembly Government (2004). Learning Disability Strategy Section 7 Guidance on Service Principles and Service Responses.

[http://www.wales.nhs.uk/sites3/Documents/480/SP\\_response\\_guide-e.pdf](http://www.wales.nhs.uk/sites3/Documents/480/SP_response_guide-e.pdf)

Department of Health (2008). Independent Inquiry into Access to Healthcare for People with Learning Disabilities.

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_099255](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_099255)

## Learning disability (LD) indicator 1

The practice can produce a register of patients aged 18 years and over with learning disabilities.

### Learning Disability 1.1 Rationale

The idea of a learning disability register for adults in primary care has been widely recommended by professionals and charities alike <sup>(151)</sup>.

Learning disability is defined in Valuing People (and 'The Same as You') as the presence of:

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

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

The definition does not include all those people who have a "learning difficulty", i.e. specific difficulties with learning, such as dyslexia.

For many people, there is little difficulty in reaching a decision whether they have a learning disability or not. However, in those individuals where there is some doubt about the diagnosis and the level of learning disability, referral to a multidisciplinary specialist learning disability team may be necessary to assess the degree of disability and diagnose any underlying condition. Locality Community Learning Disability Teams, working along with PCOs, have provided expertise and data about and for people with learning disabilities. Practices should liaise with Social Services Departments, Community Learning Disability Teams and Primary Healthcare Facilitators where employed by PCOs to assist in the construction of a primary care database <sup>(152)</sup>.

Further information

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

Public Health Institute of Scotland's Autistic Spectrum Disorder (2001). Needs Assessment Report. <http://www.scotland.gov.uk/Publications/2006/02/28094616/0>

---

<sup>(151)</sup> See Treat Me Right, Mencap (2004). [www.mencap.org.uk](http://www.mencap.org.uk)

<sup>(152)</sup> See Martin and Martin. Journal of Learning Disabilities, 2000; 4(1): 37-48.

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

## **Learning Disability 1.2 Reporting and verification**

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

### **Learning disability (LD) indicator 2 (NICE menu NM04)**

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

## **Learning Disability 2.1 Rationale**

Children and adults with Down's Syndrome are at increased risk of thyroid dysfunction, particularly hypothyroidism, compared with the general population, and the incidence of thyroid dysfunction increases with age<sup>(153)</sup>. Poor thyroid function can impair an individual's quality of life. Earlier intervention and management can help to improve health outcomes.

## **Learning Disability 2.2 Reporting and verification**

The practice reports the percentage of patients on the learning disability register with Down's Syndrome aged 18 years and over with a record of blood TSH (thyroid stimulating hormone) in the preceding 15 months. Patients with a diagnosis of hypothyroidism should be excluded from this indicator as these patients should be managed according to the hypothyroid indicator set.

---

<sup>(153)</sup> Rooney S, Walsh E (1997) Prevalence of abnormal thyroid function in a down's syndrome population. International Journal of Medical Science 166: 80–2.

## Smoking

Indicator	Points	Payment stages
<b>On-going management</b>		
Smoking 3. The percentage of patients with any or any combination of the following conditions: CHD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 15 months	30	40-90%
Smoking 4. The percentage of patients with any or any combination of the following conditions: CHD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who smoke whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered within the preceding 15 months	30	40-90%

### Smoking indicator 3

The percentage of patients with any or any combination of the following conditions: CHD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 15 months.

#### Smoking 3.1 Rationale

Coronary heart disease

Smoking is known to be associated with an increased risk of CHD.

SIGN clinical guideline 97 (2007). European Task Force European Society of Cardiology. [www.sign.ac.uk/guidelines/fulltext/97/index.html](http://www.sign.ac.uk/guidelines/fulltext/97/index.html)

European Society of Cardiology. European Guidelines. CVD Prevention in clinical practice. <http://www.escardio.org/guidelines-surveys/esc-guidelines/pages/cvd-prevention.aspx>

Stroke/TIA

There are few randomised clinical trials of the effects of risk factor modification in the secondary prevention of ischaemic or haemorrhagic stroke. However inferences can be drawn from the findings of primary prevention trials that cessation of cigarette smoking should be advocated. Grade C.

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

Hypertension



There is no strong direct link between smoking and blood pressure. However, there is overwhelming evidence of the relationship between smoking and cardiovascular and pulmonary diseases. NICE clinical guideline 34 <sup>(154)</sup> on hypertension recommends that people who smoke are offered advice and help to stop smoking.

Formal estimation of CHD risk should be undertaken.

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

- Framingham
- Joint British Society 2 (JBS2)
- QRISK
- Assessing cardiovascular risk using SIGN guidelines to assign preventive treatment (ASSIGN - Scotland only)

See CVD primary prevention indicator set for full details of the above risk tools.

### Diabetes

The risk of vascular complications in patients with diabetes is substantially increased. Smoking is an established risk factor for cardiovascular and other diseases.

### COPD

Smoking cessation is the single most effective - and cost-effective - intervention to reduce the risk of developing COPD and stop its progression.

NICE clinical guideline 101 (2010). Management of chronic obstructive pulmonary disease in adults in primary and secondary care. <http://guidance.nice.org.uk/CG101>

GOLD Guidelines. Grade A Evidence. [www.goldcopd.com/](http://www.goldcopd.com/)

### Asthma

There are a surprisingly small number of studies on smoking related to asthma. Starting smoking as a teenager increases the risk of persisting asthma. One controlled cohort study suggested that exposure to passive smoke at home delayed recovery from an acute attack. Grade A evidence suggests that smoking reduces the benefits of inhaled steroids and this adds further justification for recording this outcome <sup>(155)</sup>.

### Chronic kidney disease

There is good evidence from observational studies that people with CKD are at increased cardiovascular risk and hence the rationale for including CKD here.

### Schizophrenia, bipolar affective disorder or other psychoses

People with serious mental illness are far more likely to smoke than the general population (61 per cent of people with schizophrenia and 46 per cent of people with bipolar disorder smoke compared to 33 per cent of the general population). Premature

---

<sup>(154)</sup> NICE clinical guideline 34 (2006). Management of hypertension in adults in primary care. <http://guidance.nice.org.uk/CG34/NICEGuidance/pdf/English>

<sup>(155)</sup> See Tomlinson et al. Thorax 2005; 60: 282-7. There is also epidemiological evidence that smoking is associated with poor asthma control. See Price et al. Clin Exp Allergy 2005; 35: 282-287.

death and smoking related diseases, such as respiratory disorders and heart disease, are however, more common among people with serious mental illness who smoke than in the general population of smokers (<sup>156</sup>).

#### Non-smokers

It is recognised that lifelong non-smokers are very unlikely to start smoking and indeed find it quite irritating to be asked repeatedly regarding their smoking status. Smoking status for this group of patients should be recorded in the preceding 15 months up to and including 25 years of age.

#### Ex-smokers

There are two ways in which a patient can be recorded as an ex-smoker. Ex-smokers can be recorded as such in the preceding 15 months. It is recognised that once a patient has been an ex-smoker for more than three years they are unlikely to restart. In recognition of this practices may choose to record ex-smoking status on an annual basis for three consecutive QOF years. Thereafter, smoking status need only be recorded if there is a change. In this instance QOF years should be interpreted as a 12 month period.

#### Smoking 3.2 Reporting and verification

The practice reports the percentage of patients on any or any combination of the named registers in whom smoking status has been recorded.

For patients who smoke this recording should be made in the preceding 15 months. Ex-smokers should be recorded as described above. Those who have never smoked should be recorded as such in the preceding 15 months up to and including 25 years of age.

### Smoking indicator 4

The percentage of patients with any or any combination of the following conditions: CHD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar disorder or other psychoses who smoke whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered within the preceding 15 months.

### Smoking 4.1 Rationale

Many strategies have been used to help people to stop smoking. A meta-analysis of controlled trials in patients post myocardial infarction showed that a combination of individual and group smoking cessation advice, and assistance reinforced on multiple occasions – initially during cardiac rehabilitation and reinforced by primary care teams – gave the highest success rates (<sup>157</sup>).

---

(<sup>156</sup>) Seymour L. Not all in the mind: the physical health of mental health service users. Mentality 2003.

(<sup>157</sup>) SIGN Guidelines 96/97. Grade B recommendation.  
[www.sign.ac.uk/guidelines/fulltext/96/index.html](http://www.sign.ac.uk/guidelines/fulltext/96/index.html). [www.sign.ac.uk/guidelines/fulltext/97/index.html](http://www.sign.ac.uk/guidelines/fulltext/97/index.html)

A number of studies have recently shown benefits from the prescription of nicotine replacement therapy or bupropion in patients who have indicated a wish to quit smoking.

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

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

Further information

NICE public health guidance 10 (2008). Smoking cessation services.  
<http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11925>

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

## **Smoking Indicator 4.2 Reporting and verification**

The practice reports the percentage of patients on any or any combination of the named registers who smoke who have a record of having been offered smoking cessation advice in the preceding 15 months.

## Section 3. Organisational domain

The organisational indicators are split into six domains:

1. Records and information about patients (A)
2. Information for patients (B)
3. Education and training (C)
4. Practice management (D)
5. Medicines management (E)
6. Quality and productivity (F)

### 1. Format

Each of the indicators (X) in the first five organisational domains has four descriptions unless it is reported electronically.

### X.1 Practice guidance

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

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

### X.2 Written evidence

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

In summary, written evidence is categorised as follows:

- Grade A – to be submitted in advance of a visit
- Grade B – to be available in the practice at the visit
- Grade C – optional or used in the event of an appeal

### X.3 Assessment visit

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

### X.4 Assessors' guidance

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

Each of the indicators (X) in the quality and productivity organisational areas has two descriptions, namely practice guidance and reporting and verification:

## **X.1 Practice Guidance**

As above.

## **X.2 Reporting and verification**

As per X.2 to X.4 above.

## **2. Equivalence – other schemes**

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

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

The RCGP Quality Practice Award (QPA) has been approved for the first five sub domains of the Organisational Indicators in the Framework. Practices should be prepared to provide evidence that they have achieved the QPA in order to meet the requirements of this domain.

## **3. Quality and Productivity Indicator set**

### **Rationale for inclusion of the indicator set**

The Quality and Productivity (QP) indicators aim to support general practices in the review of current practice, both within the practice itself and with external peers. This review would be informed by the analysis of data specific to the practice in covering three areas, in order to understand the reasons for variation in performance and if appropriate to address any underlying reasons. The three areas are:

- prescribing
- first outpatient referrals
- emergency admissions

Practices as a provider of primary care services and a gateway to secondary care services, should be prepared to make the most effective use of available NHS resources (including skills, premises and treatments) to deliver improvements to the population's health and social wellbeing. This is in line with the GMC's Good Medical Practice guidance (<sup>158</sup>).

To ensure that this is delivered, practices are expected to:

---

(<sup>158</sup>) GMC's Good Medical Practice guidance. [http://www.gmc-uk.org/guidance/good\\_medical\\_practice.asp](http://www.gmc-uk.org/guidance/good_medical_practice.asp)

- avoid duplicating work through ensuring clear communication, partnership working and appropriate information sharing with all parts of the health service and where relevant social care services
- minimise waste in prescribing and ineffective treatments; and
- engage effectively in the prevention of ill health to avoid the need for costly treatments by proactively managing patients to recovery through the whole care pathway in acting as conscientious gatekeepers to services.

For the purpose of the Quality and Productivity indicators a care pathway is a defined process of diagnosis, treatment and care for a defined group of patients during a defined period.

The Quality and Productivity indicators will remain in force until 31 March 2012.

In line with other indicators within the organisational domain, exception reporting will not apply.

## Records and information

	Indicator	Points
Records 3	The practice has a system for transferring and acting on information about patients seen by other doctors out of hours	1
Records 8	There is a designated place for the recording of drug allergies and adverse reactions in the notes and these are clearly recorded	1
Records 9	For repeat medicines, an indication for the drug can be identified in the records (for drugs added to the repeat prescription with effect from 1 April 2004). Minimum Standard 80%	4
Records 11	The blood pressure of patients aged 45 years and over is recorded in the preceding 5 years for at least 65% of patients	10
Records 13	There is a system to alert the out of hours service or duty doctor to patients dying at home	2
Records 15	The practice has up to date clinical summaries in at least 60% of patient records	25
Records 17	The blood pressure of patients aged 45 years and over is recorded in the preceding 5 years for at least 80% of patients	5
Records 18	The practice has up to date clinical summaries in at least 80% of patient records	8
Records 19	80% of newly registered patients have had their notes summarised within 8 weeks of receipt by the practice	7
Records 20	The practice has up to date clinical summaries in at least 70% of patient records	12
Records 23	The percentage of patients aged 15 years and over whose notes record smoking status in the preceding 27 months (Payment stages 40–90%)	11

### Records indicator 3

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

### Records 3.1 Practice guidance

Good Medical Practice for General Practitioners (GMP for GPs) 2008 states that the excellent GP “can demonstrate an effective system for transferring and acting on

information from other doctors about patients”. Out of hours reviews in England and Scotland have emphasised the importance of the effective transfer of information.

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

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

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

### **Records 3.2 Written evidence**

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

### **Records 3.3 Assessment visit**

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

### **Records 3.4 Assessors’ guidance**

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

## **Records indicator 8**

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

### **Records 8.1 Practice guidance**

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

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

### **Records 8.2 Written evidence**

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

### **Records 8.3 Assessment visit**

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



## **Records 8.4 Assessors' guidance**

The place where drug allergies are recorded can be on the computer or in the paper records. This information should be easily available to the prescribing clinician at the time of consultation.

## **Records indicator 9**

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

Minimum standard 80 per cent.

## **Records 9.1 Practice guidance**

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

It is recognised that most practices utilise computer systems for repeat prescriptions and it is intended that an IT solution will be available to assist practices in meeting this indicator.

In practices where the computer is not utilised for repeat prescriptions, the clinician should write clearly in the patient record the diagnosis relating to the prescription. This need only be done once when the medication is initiated.

The survey to show compliance should be a minimum of 50 patients who have been commenced on a new repeat prescription from 1 April 2004.

## **Records 9.2 Written evidence**

A survey of the drugs used should be carried out. The survey should show an indication can be identified for at least 80 per cent of repeat medications commenced after 1 April 2004. (Grade A)

## **Records 9.3 Assessment visit**

The records should be inspected.

## **Records 9.4 Assessors' guidance**

As part of the inspection of records those drugs which have been added to the repeat prescription from 1 April 2004 should be identified and an indication for starting them should be clear. The help of practice staff may be required to achieve this. The records of twenty patients for whom repeat medication has been started since that date should be surveyed. If the standard is not achieved then a further twenty clinical records should be surveyed and the cumulative total should be used.

The minimum standard is that 80 per cent of the indications for repeat medication drugs can be identified.

## **Records indicator 11**

The blood pressure of patients aged 45 years and over is recorded in the preceding five years for at least 65 per cent of patients.

### **Records 11.1 Practice guidance**

Detecting elevated blood pressure and treating it is known to be an effective health intervention. The limit to patients aged 45 years and over has been pragmatically chosen as the vast majority of patients develop hypertension after this age. It is anticipated that practices will opportunistically check blood pressures in all adult patients.

Depending on whether practices record blood pressure in the computer or manual record, the survey can be undertaken by computer search or a survey of the written records.

A similar indicator is Records Indicator 17 but a higher standard must be achieved.

### **Records 11.2 Written evidence**

A survey of the records of patients 45 years of age and over (a minimum of 50 records) or a report from a computer search should be carried out, showing that blood pressure has been recorded in the preceding five years. (Grade A)

### **Records 11.3 Assessment visit**

A random sample of 20 notes or computerised records of patients 45 years of age and over should be inspected, to confirm that blood pressure has been recorded in the preceding five years.

### **Records 11.4 Assessors' guidance**

The practice's own survey may be verified by inspecting 20 clinical records of patients aged 45 years and over at the visit. If the result differs from the practice survey, then a further 20 records need to be checked.

Note: A logical query and dataset (business rule) is available to support this indicator.

## **Records Indicator 13**

There is a system to alert the out of hours service or duty doctor to patients dying at home.

### **Records 13.1 Practice guidance**

Good Medical Practice (2008) states that when off duty the doctor ensures there are arrangements which “include effective handover procedures and clear communication

between doctors”. It is especially important for patients who are terminally ill and likely to die in the near future at home or where clinical management is proving difficult or challenging.

The practice should have developed a system with their out of hours care provider to transfer information from the practice to that provider about patients that the attending doctor anticipates may die from a terminal illness in the next few days and hence may require medical services in the out of hours period. If a practice performs its own on call duties then a system should ensure that all doctors in the practice are aware of these patients. A single handed doctor who usually covers his or her own patients out of hours should have a similar system in place when he or she is absent from the practice e.g. on holiday.

### **Records 13.2 Written evidence**

The system for alerting the out of hours service or duty doctor to patients dying at home should be described. (Grade C)

### **Records 13.3 Assessment visit**

The doctors in the practice should be questioned on the system that is in place.

### **Records 13.4 Assessors’ guidance**

The team should be questioned on their system by asking for recent examples of patients who have been terminally ill and/or dying at home and what information was passed to the out of hours service or duty doctor.

### **Records indicator 15**

The practice has up to date clinical summaries in at least 60 per cent of patient records.

### **Records 15.1 Practice guidance**

GMP for GPs (2008) states “Important information in records should be easily accessible, for example, as part of a summary”.

If a system for producing summaries is not in place then this will involve a great deal of work. The practice will need to decide which conditions it will include in the summary. The practice would be expected to have a policy on what is included in the summary. All significant past and continuing problems should be included.

If a computer is used, the practice will need to decide which Read codes to use for common conditions. It is best to use a set of codes that has been agreed within a PCO or nationally to allow comparison and exchange of data. Practices should adhere to the joint RCGP/GPC guidance on record keeping.

Similar indicators are Records 18 and Records 20 but higher standards must be achieved.

## **Records 15.2 Written evidence**

A survey of patient records (minimum 50) should be carried out, recording the percentage that have clinical summaries and the percentage which are up to date. (Grade A)

## **Records 15.3 Assessment visit**

A random sample of 20 patient records should be examined to confirm the percentage that have clinical summaries and the percentage which are up to date.

## **Records 15.4 Assessors' guidance**

The practice's own survey is verified by inspecting 20 clinical records. If the result differs from the practice survey then a further 20 records need to be checked. Assessors may need to clarify with the practice what information they would normally include in a clinical summary ensuring that they do not assess this indicator based on their own experience and beliefs.

Note: A logical query and dataset (business rule) is available to support this indicator.

In Scotland, manual submission of achievement continues and is reviewed by the Scottish Government and Scottish General Practitioners Committee of the BMA annually. Please refer to your PCO for current information.

## **Records indicator 17**

The blood pressure of patients aged 45 years and over is recorded in the preceding 5 years for at least 80% of patients.

## **Records 17.1 Practice guidance**

See Records 11.1.

## **Records 17.2 Written evidence**

See Records 11.2. (Grade A)

## **Records 17.3 Assessment visit**

See Records 11.3.

## **Records 17.4 Assessors' guidance**

See Records 11.4.

## **Records indicator 18**

The practice has up to date clinical summaries in at least 80% of patient records.

## **Records 18.1 Practice guidance**

See Records 15.1.

## **Records 18.2 Written evidence**

See Records 15.2. (Grade A)

## **Records 18.3 Assessment visit**

See Records 15.3.

## **Records 18.4 Assessors' guidance**

See Records 15.4.

## **Records indicator 19**

Eighty per cent of newly registered patients have had their notes summarised within eight weeks of receipt by the practice.

### **Records 19.1 Practice guidance**

The criterion refers to the time the notes have been received by the practice and not the time of registration. For some practices that take on many patients at a set time of year achievement of the indicator will require some forward planning.

Read codes may be utilised to record this information and can then be searched for on the practice computer system.

### **Records 19.2 Written evidence**

A survey should be carried out of the records of newly registered patients whose notes have been received between eight and 26 weeks previously (either a sample of 30 or all patients if there have been fewer than 30 such registrations), noting if the records have been received and summarised.

Alternatively a computer print-out should be examined, showing the patients registered where the records have been received between eight and 26 weeks previously, to confirm whether the computer record contains a clinical summary. (Grade A)

### **Records 19.3 Assessment visit**

A sample of 20 records of patients whose records were sent to the practice between nine and 26 weeks ago should be examined, to ascertain if the records have arrived and have been summarised.

## **Records 19.4 Assessors' guidance**

A list of patients registered in the past 12 months and whose records have been forwarded between nine and 26 weeks ago to the practice will be obtained from the PCO. A sample of 20 records, or all if there have been fewer of these patients, will be checked. If the result differs significantly (at least ten per cent) from the practice survey a further 20 records will be checked if appropriate.

## **Records indicator 20**

The practice has up to date clinical summaries in at least 70% of patient records.

### **Records 20.1 Practice guidance**

See Records 15.1.

### **Records 20.2 Written evidence**

See Records 15.2. (Grade A)

### **Records 20.3 Assessment visit**

See Records 15.3.

### **Records 20.4 Assessors guidance**

See Records 15.4.

## **Records indicator 23**

The percentage of patients aged 15 years and over whose notes record smoking status in the preceding 27 months.

### **Records 23.1 Practice guidance**

There is evidence that when doctors and other health professionals advise patients to stop smoking, this is effective. This indicator examines whether smoking status is recorded in the clinical record. Current smokers should be recorded as such in the preceding 27 months. Non-smokers should be recorded as such in the preceding 27 months up to and including 25 years of age. New patients aged 26 years and over should be recorded as non-smokers at least once.

There are two ways in which a patient can be recorded as an ex-smoker. Ex-smokers can be recorded as such in the preceding 27 months.

It is recognised that once a patient has been an ex-smoker for more than three years they are unlikely to restart. In recognition of this practices may choose to record ex-smoking status on an annual basis for three consecutive QOF years. Thereafter, smoking status need only be recorded if there is a change. In this instance QOF years should be interpreted as a 12 month period.

### **Records 23.2 Written evidence**

A survey of written records or a computer search of patients aged 15 years and over should be carried out (surveying a minimum of 50 records), to determine the percentage where smoking habit is recorded. For current smokers this record should be in the preceding 27 months. Ex-smokers should be recorded as described above. Those who have never smoked should be recorded as such in the preceding 27 months up to and including 25 years of age. (Grade A)

### **Records 23.3 Assessment visit**

A random sample of 20 notes or computerised records of patients aged 15 years and over should be inspected, to confirm that smoking status is recorded as detailed above.

### **Records 23.4 Assessors' guidance**

The practice's own survey is verified by inspecting 20 patient records at the visit. If the result differs from the practice survey then a further 20 patient records should be checked.

Note: A logical query and dataset (business rule) is available to support this indicator.

## Information for patients

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

### Information indicator 5

The practice supports smokers in stopping smoking by a strategy which includes providing literature and offering appropriate therapy.

#### Information 5.1 Practice guidance

There is good evidence about the effectiveness of healthcare professionals in assisting patients to stop smoking.

A number of studies have recently shown benefits from the prescription of nicotine replacement therapy or bupropion in patients who have indicated a wish to quit smoking.

The strategy does not need to be written by the practice team. A local or national protocol could be adapted for use specifically by the practice and implemented. The provision of dedicated smoking cessation services remains the responsibility of the PCO.

#### Information 5.2 Written evidence

There should be a practice protocol concerning smoking cessation. (Grade A)

#### Information 5.3 Assessment visit

Prescribing data should be reviewed, and literature available for patients who wish to quit should be examined.

#### Information 5.4 Assessors' guidance

The strategy should take into account current evidence in this area. Signs of implementation may be evident in the practice's prescribing data or in the patient leaflets that are used by the practice.



## Education and training

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

### Education indicator 1

There is a record of all practice-employed clinical staff having attended training/updating in basic life support skills in the preceding 18 months.

#### Education 1.1 Practice guidance

The primary care team members, including GPs deal with cardio-pulmonary collapse relatively rarely, but require up to date skills to deal with an emergency. This is best undertaken at regular intervals through practical skills-based training sessions, as it is

known that these skills diminish after a relatively short time. The timescale has been set pragmatically at 18 months, although many practices offer training on a more frequent basis.

This training may be available from a variety of providers including your local Accident and Emergency Department, BASICS, the PCO, out of hours cooperative, Red Cross, St John's Ambulance or equivalent. It may be sufficient for one individual in the team to attend for external training and then cascade this within the team.

Further information

Cardiopulmonary Resuscitation Guidance for Clinical Practice and Training in Primary Care (2001). [www.resus.org.uk/pages/cpatpc.htm#contents](http://www.resus.org.uk/pages/cpatpc.htm#contents)

Resuscitation Council UK (2005). Resuscitation guidelines.  
<http://www.resus.org.uk/pages/guide.htm>

## **Education 1.2 Written evidence**

Attendance at Basic Life Savings (BLS) training should be listed. (Grade B)

## **Education 1.3 Assessment visit**

Staff should be questioned on the date of their last basic life support skills (BLS) training.

## **Education 1.4 Assessors' guidance**

Assessors should confirm by checking the BLS attendance list that practice-employed clinical staff have attended.

## **Education indicator 5**

There is a record of all practice-employed staff having attended training/updating in basic life support skills in the preceding 36 months.

## **Education 5.1 Practice guidance**

Although it is rare for practice non-clinical staff to have to deal with a cardio-pulmonary collapse, the situation may arise within or outwith the practice premises.

See Education 1.

The interval for training is pragmatically set at three years although many practices offer training on a more frequent basis.

## **Education 5.2 Written evidence**

Attendance at BLS training should be listed. (Grade B)

### **Education 5.3 Assessment visit**

Staff should be questioned on the date of their last BLS training.

### **Education 5.4 Assessors' guidance**

Confirmation that practice non-clinical staff have attended training should be obtained by checking the BLS attendance list.

### **Education indicator 6**

The practice conducts an annual review of patient complaints and suggestions to ascertain general learning points which are shared with the team.

### **Education 6.1 Practice guidance**

Practices and clinicians generally find complaints stressful. It is important that the practice view complaints as a potential source for learning and for change and development.

Reports should include a summary of each complaint or suggestion and an identification of any learning points which came out of the review. It may be useful to agree at the time of each review how the learning points or areas for change will be communicated to the team; it is likely that not all team members will be involved in every review meeting for various reasons. It may also be useful to identify an individual responsible for implementing the change and monitoring its progress.

These reports may form part of the written evidence for the indicators on significant event analysis (indicators Education 7 and Education 10).

### **Education 6.2 Written evidence**

Reports/minutes of team meetings where learning points have been discussed should be made, with a note of the changes made as a result. (Grade A)

### **Education 6.3 Assessment visit**

The issue of learning from complaints should be discussed with staff and GPs.

### **Education 6.4 Assessors' guidance**

Assessors should discuss with team members their involvement in reviews of patient complaints and suggestions and how the learning points are shared with the team.

### **Education indicator 7**

The practice has undertaken a minimum of 12 significant event reviews in the past three years which could include:

- any death occurring in the practice premises
- new cancer diagnoses

- deaths where terminal care has taken place at home
- any suicides
- admissions under the Mental Health Act
- child protection cases
- medication errors
- a significant event, occurring when a patient may have been subjected to harm, had the circumstance/outcome been different (near miss).

### **Education 7.1 Practice guidance**

Detail of methodology on significant event analysis is given in indicator Education 10.

This indicator is more prescriptive in the requirement to report on specific occurrences in the practice. Clearly if certain of these events have not occurred, e.g. patient suicide, then this should be stated in the evidence.

### **Education 7.2 Written evidence**

Each review case report must consist of a short commentary setting out the relevant history, the circumstances of the episode and an analysis of the conclusions to be drawn.

Evidence should be presented of any clinical and organisational changes resulting from the analysis of these cases. (Grade A)

### **Education 7.3 Assessment visit**

The reviews should be discussed.

### **Education 7.4 Assessors' guidance**

The practice should report on its analyses in a form consistent with either of the two methods described in indicator Education 10.

## **Education indicator 8**

All practice employed nurses have personal learning plans which have been reviewed at annual appraisal.

### **Education 8.1 Practice guidance**

The production of a personal learning plan should be one of the outcomes of the appraisal system and the points allocated to this indicator have been allocated to reflect this. The plan should record the agreement between appraiser(s) and appraisee on areas for further learning, how they will be achieved, who is responsible for organising them, within what timescale and how progress will be reviewed. It may also include learning areas which have been identified as an organisational need but

which have been agreed at the appraisal as an individual development area for the appraisee to take forward. This information should be recorded.

An annual appraisal can reasonably be extended to employed members of the nursing team e.g. Health Care Assistants (HCA's) who have direct patient contact. This supports good practice arrangements.

### **Education 8.2 Written evidence**

The staff appraisal system should be described. (Grade C)

### **Education 8.3 Assessment visit**

A discussion should be held with practice employed nursing staff (including employed members of the nursing team e.g. HCAs who have direct patient contact) about their personal learning plans and the appraisal system.

### **Education 8.4 Assessors' guidance**

Personal learning plans and the appraisal system should be discussed with practice employed nursing staff (including employed members of the nursing team e.g. HCAs who have direct patient contact) and the person responsible for managing the appraisal system.

## **Education indicator 9**

All practice employed non-clinical team members have an annual appraisal.

### **Education 9.1 Practice guidance**

Appraisal is a constructive opportunity to review performance objectives, progress and skills and identify learning needs in a protected environment. The learning needs identified may be personal to the appraisee and/or organisational learning needs which the appraisee has agreed to fulfil. The outcome of the appraisal should be a written action plan agreed between appraiser and appraisee which could include a personal learning plan for the appraisee. In addition the opportunity could be taken to review and update the appraisee's job description.

### **Education 9.2 Written evidence**

The staff appraisal system should be described. (Grade C)

### **Education 9.3 Assessment visit**

A discussion should be held with practice employed non-clinical staff about their experience of appraisal.

### **Education 9.4 Assessors' guidance**

It may be useful to discuss the appraisal system with the non-clinical staff themselves, the practice manager and the GPs.

## Education indicator 10

The practice has undertaken a minimum of three significant event reviews within the preceding year.

### Education 10.1 Practice guidance

Significant event review is a recognised methodology for reflecting on important events within a practice and is an accepted process as evidence for GMC revalidation.

Significant event analysis is not new, although its terminology may have changed. It was first known as critical event monitoring. It provides structure to an activity which anyway happens informally between health care professionals. It is the discussion of cases and events and the learning obtained through reflection and is an extension of audit activity. Discussion of specific events can provoke emotions that can be harnessed to achieve change. For it to be effective, it needs to be practised in a culture that avoids allocating blame and involves all disciplines within the practice.

The following steps are useful in introducing significant event analysis to a practice:

1. A multidisciplinary meeting to explain the concept.
2. Consideration of events which should be important to the practice but need not imply criticism of the practice or of individuals. The practice can construct a core list as a basis to stimulate discussion or it can use the one published in the RCGP Occasional Paper. Some of the examples from this are below.

Preventative care:	Measles Unplanned pregnancy Non-accidental injury Squint diagnosed by an ophthalmologist
Acute care:	Sudden unexpected death Death occurring on the practice premises Suicide or suicide attempt All new cancer diagnoses Myocardial Infarction Terminal care death at home Section under Mental Health Act
Chronic disease:	Diabetic hypoglycaemia Leg ulcer or amputation Asthma - hospitalisation Epilepsy – status epilepticus
Organisation:	Investigation received but not acted upon Breach of confidentiality Any patient complaints Upsetting of staff

3. Mechanism for identification of events. A logbook kept at reception may be helpful or an electronic logbook held on the practice computer system. Any mechanism should allow all team members to contribute.

4. Significant events meetings. These are generally multidisciplinary but need not be so and need to be sensitively chaired. Notes should be taken but should not include patient identification. Each attendee should be encouraged to take along at least one significant event. The meeting can choose which to discuss first and anybody can have the right to veto if that area is considered too sensitive.

The events are then discussed, first highlighting the aspects of high standard and then those standards that can be improved. A decision about the case needs to be reached. This could be:

- celebration of excellent care
- no change
- audit required
- immediate change required

Follow-up of these decisions should be arranged and this may occur at the next significant event analysis meeting.

These reports should be laid out in a form consistent with either of the two following suggested formats:

A.

- Description of event. This should be brief and can be in note form.
- Learning outcome. This should describe the aspects which were of high standard and those which could be improved. Where appropriate it should include why the event occurred.
- Action plan. The decision(s) taken need to be contained in the report. The reasons for these decisions should be described together with any other lessons learned from the discussion.

B.

- What happened?
- Why did it happen?
- Was insight demonstrated?
- Was change implemented?

Further information

A description of significant event audit is also available in: Robinson et al. How to Do It: Use facilitated case discussions for significant event auditing <sup>(159)</sup>.

NPSA/RCGP (2008). SEA guidance for Primary Care Teams.

<http://www.npsa.nhs.uk/nrls/improvingpatientsafety/primarycare/significant-event-audit/>

---

<sup>(159)</sup> BMJ 1995; 311: 315-318.

## **Education 10.2 Written evidence**

Each case report should consist of a short commentary setting out the relevant history, the circumstances of the episode and an analysis of the conclusions to be drawn.

Evidence should be presented of any clinical and organisational changes resulting from the analysis of these cases. (Grade A)

## **Education 10.3 Assessment visit**

The reviews should be discussed.

## **Education 10.4 Assessors guidance**

The practice should report their analyses in a form consistent with either of the two following methods:

statement of the problem or event, learning outcome and action plan;

OR

What happened? Why did it happen? Was insight demonstrated? Was change implemented?

The practice should involve, if possible, all team members who were stakeholders in the event in the case discussion



## Practice management

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

### Management indicator 1

Individual healthcare professionals have access to information on local procedures relating to child protection.

### Management 1.1 Practice guidance

Awareness of the existence of local child protection procedures is mandatory and all healthcare professionals should be able to access a copy.

## **Management 1.2 Written evidence**

There should be a description of how local procedures are accessed. (Grade C).

## **Management 1.3 Assessment visit**

Access to local procedures should be demonstrated.

## **Management 1.4 Assessors' guidance**

The assessors should check with team members what action they would take if they had reason to suspect that a child might be being abused, including which local procedures they would refer to and how.

## **Management indicator 2**

There are clearly defined arrangements for backing up computer data, back-up verification, safe storage of back-up tapes and authorisation for loading programmes where a computer is used.

## **Management 2.1 Practice guidance**

The practice should have a written policy which defines who is responsible for backing up data, how it is done and how often it is done. It is good practice to keep weekly and monthly backups as well as daily backups using a rotation of back-up tapes or their equivalent. It is good practice to keep a log. Tapes should be renewed at specified intervals. Verification of backups should also be carried out at regular specified intervals, especially in paper-light or paperless practices. Tapes should be stored in a fireproof safe, with a procedure in place for back-up tapes being stored off site in order to ensure confidentiality. The policy should also define the individuals who are authorised to load new software programmes.

## **Management 2.2 Written evidence**

There should be written policy regarding:

- backing up data and verification, including the frequency of that back-up
- storage on and off site
- authorisation to load programmes. (Grade A)

## **Management 2.3 Assessment visit**

The back-up and loading arrangements should be demonstrated.

## **Management 2.4 Assessors' guidance**

The arrangements for back-up, verification and storage procedures should be checked with the responsible staff member. It is important to ascertain that staff are aware of the procedure for authorisation for loading new software.

## **Management indicator 3**

The Hepatitis B status of all doctors and relevant practice employed staff is recorded and immunisation recommended if required in accordance with national guidance.

## **Management 3.1 Practice guidance**

Useful guidance on Hepatitis B risks and immunisation is contained in the UK Health Departments' publication *Guidance for Clinical Health Care Workers: protection against infection with blood borne viruses - recommendations of the Expert Advisory Group on AIDS and the Advisory Group on Hepatitis* ([www.dh.gov.uk/assetRoot/04/01/44/74/04014474.pdf](http://www.dh.gov.uk/assetRoot/04/01/44/74/04014474.pdf)).

Under the Health and Safety at Work etc Act (1974) (HSWA), GPs are legally obliged to make sure that all employees receive appropriate training and know the procedures for working safely. They must also carry out risk assessments and these could include assessing procedures under the Control of Substances Hazardous to Health Regulations 1994 (COSHH). These regulations would cover employees who have direct contact with patients' blood, other potentially infectious bodily fluids or tissues. Immunisation of doctors and staff that have direct contact with these substances is recommended in the above regulations.

The Department of Health guidance *Protecting Health Care Workers and Patients from Hepatitis B and the 1996 and 2004 addenda* (see above reference to the website, Annex 1) states that all health care workers who perform exposure prone procedures (EPPs) should be immunised. They should have their response to the vaccine checked and non-responders to vaccination should be investigated for infection in order to minimise risk to patients. This guidance also states that workers whose Hepatitis B status is unknown should be tested before carrying out EPPs.

Immunisation provides protection in up to 90 per cent of patients vaccinated, but is not a substitute for good infection control procedures.

The BMA website provides a specimen Hepatitis B immunisation policy in the general practice staff (non-medical) specimen handbook. Advice on suitable immunisation policies can also be obtained from the Occupational Health Service, which works with reference to guidelines published in *Immunisation against Infectious Disease* (see Annex 1 in the above website).

In relation to confidentiality, the BMA Website offers the following guidance: "It is extremely important that Hepatitis B infected health care workers have the same right of confidentiality as any patient seeking or receiving medical care.

Occupational health notes are separate from other hospital notes and occupational health physicians are ethically and professionally obliged not to release information

without the consent of the individual. There are occasions when an employer may need to be advised that a change of duties should take place, but Hepatitis B status itself will not normally be disclosed without the health care worker's consent. However, where patients are, or have been, at risk of exposure to Hepatitis B from an infected healthcare worker, it may be necessary in the public interest for the employer to have access to confidential information”.

### **Management 3.2 Written evidence**

There should be evidence that the Hepatitis B status of all staff is known. (Grade C)

### **Management 3.3 Assessment visit**

Questioning should take place on the system to check Hepatitis B status.

### **Management 3.4 Assessors' guidance**

It should be confirmed that evidence is available that the Hepatitis B status of all doctors and relevant practice-employed staff has been recorded and that there is a mechanism for recommending (and recording any recommendation) regarding vaccination to the doctor or staff member, including checking response to vaccination.

## **Management indicator 5**

The practice offers a range of appointment times to patients, which as a minimum should include morning and afternoon appointments five mornings and four afternoons per week, except where agreed by the PCO.

### **Management 5.1 Practice guidance**

In practices which operate with open surgeries, this would mean that the practice should have a range of times of availability equivalent to the appointment range in the indicator. Patients should be offered a reasonable range of appointment times, which are advertised to them. The practice's appointment system should normally offer as a minimum the range of appointments described in the practice leaflet. In remote and rural areas, for example, or in some single-handed practices, the range of appointment availability described in the indicator will not be appropriate. In these circumstances, the practice should agree its availability with the PCO and this should be advertised in the practice leaflet. Evidence that this has been agreed should be made available to the assessor.

### **Management 5.2 Written evidence**

The practice leaflet should be scrutinised for evidence of appointment times. (Grade A)

### **Management 5.3 Assessment visit**

The practice leaflet and appointment book should be checked.

## **Management 5.4 Assessors' guidance**

The assessor should check that the practice advertises in the practice leaflet a range of appointment times which corresponds to the indicator. The availability of such appointments should be confirmed by looking at a randomly selected week in the appointment book/appointment system. In practices offering a more limited range of appointment availability, the practice should provide evidence that the PCO has agreed the range on offer.

## **Management indicator 7**

The practice has systems in place to ensure regular and appropriate inspection, calibration, maintenance and replacement of equipment including:

- a defined responsible person
- clear recording
- systematic pre-planned schedules
- reporting of faults.

## **Management 7.1 Practice guidance**

The evidence for this criterion may form part of the statutory risk assessment activity which takes place under the Health and Safety at Work Regulations 1999 (Management Regulations). Comprehensive guidance on risk assessment can be found in the Health and Safety Executive's website on [www.hse.gov.uk](http://www.hse.gov.uk). The website provides a free booklet "Five Steps to Risk Assessment".

This website also contains a free leaflet "Maintaining portable electrical equipment in offices and other low risk environments". This contains guidance on the appropriate person to inspect and maintain equipment in relation to the equipment's associated risks as well as suggested intervals between inspections and maintenance. For example, a printer may be inspected and maintained by a "competent" person with enough knowledge and training, who need not be an electrician. This is only one of several free leaflets available on the website, others may also be relevant to the individual practice's circumstances.

The schedule should clearly identify who has overall responsibility, who is the appropriate individual to inspect/maintain/calibrate each piece of equipment, the intervals between inspections and the system for reporting faults.

## **Management 7.2 Written evidence**

Details should be given of the system to ensure regular and appropriate inspection, calibration, maintenance and replacement of equipment meeting the stated criteria. (Grade B)

## **Management 7.3 Assessment visit**

Assessors should undertake a review of equipment requiring maintenance, and the log of inspection and maintenance.

## **Management 7.4 Assessors' guidance**

The practice should have in place a system which includes risk assessment of equipment and a schedule of inspection, calibration and maintenance. This should include electrical equipment.

The responsible person will not always be the person actually carrying out the inspection; this should be specified in the schedule. The intervals between inspection, calibration and maintenance will be different for various types of equipment dependent on their associated level of risk. Inspection, calibration and maintenance should be recorded.

There should be a clear system for reporting faults.

The practice should be able to provide a written record of inspection, calibration and maintenance for some randomly selected pieces of equipment. It would be useful to consider a range of equipment from small items (e.g. printer) up to larger items such as a steriliser or defibrillator.

## **Management indicator 9**

The practice has a protocol for the identification of carers and a mechanism for the referral of carers for social services assessment.

### **Management 9.1 Practice guidance**

The practice should have a procedure for how carers are identified and a referral protocol to social services for assessment of carers support needs or to other local support such as carers centre.

A carer is defined as, someone who, without payment, provides help and support to a partner, relative, friend or neighbour, who could not manage to stay at home without their help due to age, sickness, addiction or disability.

The practice should remember to include any young carers who are particularly vulnerable.

Further information

Focus on Carers and the NHS-identifying and supporting hidden carers. Good Practice. <http://www.carers.org/publications,185,GP.html>

Scottish Government and COSLA carers strategy 2010-15.  
<http://www.scotland.gov.uk/Publications/2010/07/23153304/0>

### **Management 9.2 Written evidence**

The protocol is available. (Grade A)

### **Management 9.3 Assessment visit**

The policy is discussed.

## **Management 9.4 Assessors' guidance**

The assessors should enquire of various team members what action they would take when they identify that a carer may benefit from social services involvement.

## **Management indicator 10**

There is a written procedures manual that includes staff employment policies including equal opportunities, bullying and harassment and sickness absence (including illegal drugs, alcohol and stress), to which staff have access.

## **Management 10.1 Practice guidance**

It is good employment practice to have established written procedures, which are available to staff, so that both staff and employer are clear about the steps to be taken if a problem arises. As well as the policies mentioned, the manual could include the Disciplinary and Grievance Procedure.

Useful guidance on writing these policies can be found as follows:

- Equal Opportunities Policy: The Equal Opportunities Commission – Guidelines for Equal Opportunities Employers on [www.eoc.org.uk/](http://www.eoc.org.uk/). Guidance can also be found on the ACAS web site on [www.acas.org.uk](http://www.acas.org.uk). The Department for Education and Skills also publishes an Equal Opportunities Ten Point Plan for Employers giving practical advice on implementing equal opportunities policies.
- Bullying and Harassment: ACAS as above.
- IHM Healthcare Management Code at [www.ihm.org.uk](http://www.ihm.org.uk).
- IHM Diversity Group recommendations for recruitment and selection.
- Sickness Absence: ACAS as above, including their booklet entitled Absence and Labour Turnover.
- BMA guidance on managing absence at [www.bma.org.uk](http://www.bma.org.uk)

## **Management 10.2 Written evidence**

Employment policies should be recorded. (Grade B). Policies should be consistent with current legislation and indicate a date when the policy has been reviewed.

## **Management 10.3 Assessment visit**

The procedures manual should be inspected.

## **Management 10.4 Assessors' guidance**

The procedures manual should contain dated copies which are made available to staff of the policies relating to their employment. It should be confirmed with employed staff that they are aware of the content of the procedures manual and its whereabouts.

## Medicines management

	<b>Indicator</b>	<b>Points</b>
<b>Medicines 2</b>	The practice possesses the equipment and in-date emergency drugs to treat anaphylaxis	2
<b>Medicines 3</b>	There is a system for checking the expiry dates of emergency drugs on at least an annual basis	2
<b>Medicines 4</b>	The number of hours from requesting a prescription to availability for collection by the patient is 72 hours or less (excluding weekends and bank/local holidays)	3
<b>Medicines 6</b>	The practice meets the PCO prescribing adviser at least annually and agrees up to three actions related to prescribing	4
<b>Medicines 8</b>	The number of hours from requesting a prescription to availability for collection by the patient is 48 hours or less (excluding weekends and bank/local holidays)	6
<b>Medicines 10</b>	The practice meets the PCO prescribing adviser at least annually, has agreed up to three actions related to prescribing and subsequently provided evidence of change	4
<b>Medicines 11</b>	A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed four or more repeat medicines Standard 80%	7
<b>Medicines 12</b>	A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed repeat medicines Standard 80%	8

### Medicines indicator 2

The practice possesses the equipment and in-date emergency drugs to treat anaphylaxis.

#### Medicines 2.1 Practice guidance

GMP for GPs (2008) states that the excellent doctor “has up to date emergency equipment and drugs” and anaphylaxis is one condition that may constitute an emergency in the practice premises.

#### Medicines 2.2 Written evidence

There is a list of equipment and drugs that the practice has available to deal with an anaphylactic emergency. (Grade C)



### **Medicines 2.3 Assessment visit**

The appropriate equipment and drugs are inspected.

### **Medicines 2.4 Assessors' guidance**

The dates of emergency drugs should be checked.

### **Medicines indicator 3**

There is a system for checking the expiry dates of emergency drugs on at least an annual basis.

### **Medicines 3.1 Practice guidance**

GMP for GPs (2008) states that the unacceptable GP “has drugs which are out of date” and a system is required to prevent this. The system should include all emergency drugs held in the practice premises and in the doctors' bags.

### **Medicines 3.2 Written evidence**

The system is described. (Grade C)

### **Medicines 3.3 Assessment visit**

A random sample of doctors' bags and other emergency drugs is checked.

### **Medicines 3.4 Assessors' guidance**

All drugs should be in date and the doctors should be questioned on the system for keeping them up to date.

### **Medicines indicator 4**

The number of hours from requesting a prescription to availability for collection by the patient is 72 hours or less (excluding weekends and bank/local holidays).

### **Medicines 4.1 Practice guidance**

Practices should provide a reasonably fast service for their repeat prescriptions. Details of how the practice's system works should be contained in the practice leaflet. If the practice can deliver the service in 48 hours, another indicator is also achieved (indicator Medicines 8).

### **Medicines 4.2 Written evidence**

The practice leaflet or policy is available (Grade A). The receptionists are questioned on the policy.

## **Medicines 4.4 Assessors' guidance**

The assessors should check that the system for issuing repeat prescriptions can be described by the receptionists and should observe it in action.

## **Medicines indicator 6**

The practice meets the PCO prescribing adviser at least annually and agrees up to three actions related to prescribing.

### **Medicines 6.1 Practice guidance**

If the PCO prescribing adviser is unable to visit within the year and there has been no contact with another PCO recognised source of prescribing advice within the year, then the practice is exempt from this indicator. In that circumstance, the practice should provide written confirmation from the PCO prescribing adviser that he or she has been unable to visit within the relevant year.

Three actions agreed with the PCO prescribing adviser should be produced, or written confirmation from the PCO prescribing adviser that he or she has been unable to visit within the relevant year. (Grade A)

### **Medicines 6.3 Assessment visit**

The actions should be discussed.

### **Medicines 6.4 Assessors' guidance**

This indicator will be considered to have been met if the prescribing advisor and the practice have reached agreement on the action points.

## **Medicines indicator 8**

The number of hours from requesting a prescription to availability for collection by the patient is 48 hours or less (excluding weekends and bank/local holidays).

### **Medicines 8.1 Practice guidance**

Patients tend to prefer a reasonably fast service for their repeat prescriptions. Details of how the practice's system works should be contained in the practice leaflet. If the practice can achieve this in 72 hours, then another indicator is achieved (indicator Medicines 4).

### **Medicines 8.2 Written evidence**

The practice leaflet or policy is available (Grade A). The receptionists are questioned on the policy.

## **Medicines 8.4 Assessors' guidance**

The assessors should check that the system for issuing repeat prescriptions can be described by the receptionists and should observe it in action.

## **Medicines indicator 10**

The practice meets the PCO prescribing adviser at least annually, has agreed up to three actions related to prescribing and subsequently provided evidence of change.

### **Medicines 10.1 Practice guidance**

Normally, improvements should be demonstrated in all three areas. However, if good reasons can be presented by the practice for not having achieved improvements, then the practice can still achieve this indicator. The practice should be able to provide written support from the PCO prescribing adviser for its reasons for not achieving the areas in question.

If the PCO prescribing adviser is unable to visit within the year, then the practice is exempt. The practice should provide written confirmation from the PCO prescribing adviser that he or she has been unable to visit within the relevant year.

### **Medicines 10.2 Written evidence**

Three actions agreed with the PCO prescribing adviser and evidence of change should be produced, and/or written support from the prescribing adviser for the reasons for not achieving change, or written confirmation from the PCO prescribing adviser that he or she has been unable to visit within the relevant year.

### **Medicines 10.3 Assessment visit**

Actions and improvements should be discussed.

### **Medicines 10.4 Assessors' guidance**

Normally, improvements should be demonstrated in all three areas. However, if good reasons can be presented by the practice for not having achieved improvements, then the practice can still achieve this indicator. The practice should be able to provide written support from the PCO prescribing adviser for its reasons for not achieving the areas in question.

## **Medicines indicator 11**

A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed four or more repeat medicines.

### **Medicines 11.1 Practice guidance**

Medication is by far the most common form of medical intervention. Four out of five people aged over 75 years take a prescription medicine and 36 per cent are taking four

or more<sup>(160)</sup>). However, we also know that up to 50 per cent of drugs are not taken as prescribed, many drugs in common use can cause problems and that adverse reactions to medicines are implicated in 5 - 17 per cent of hospital admissions.

Involving patients in prescribing decisions and supporting them in taking their medicines is a key part of improving patient safety, health outcomes and satisfaction with care. Medication review is increasingly recognised as a cornerstone of medicines management. It is expected that at least a Level 2 medication review will occur, as described in the briefing paper linked below:

[http://www.npc.co.uk/med\\_partnership/medication-review/room-for-review/downloads.html](http://www.npc.co.uk/med_partnership/medication-review/room-for-review/downloads.html)

The underlying principles of any medication review, whether using the patient's full notes or face to face are:

1. All patients should have the chance to raise questions and highlight problems about their medicines.
2. Medication review seeks to improve or optimise impact of treatment for an individual patient.
3. The review is undertaken in a systematic way by a competent person.
4. Any changes resulting from the review are agreed with the patient.
5. The review is documented in the patient's notes.
6. The impact of any change is monitored.

Medicines DO NOT include dressings and emollients but would include topical preparations with an active ingredient such as steroid creams and ointments and hormone preparations.

## **Medicines 11.2 Written information**

A survey of medication review should be undertaken (Grade A). This could be a computerised search and print out or a survey of 50 records of patients on four or more medications.

## **Medicines 11.3 Assessment visit**

Inspection of records should be carried out.

## **Medicines 11.4 Assessors' guidance**

The assessors should ask the staff to demonstrate how the system works and in particular how an annual review is ensured.

## **Medicines indicator 12**

A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed repeat medicines.

---

<sup>(160)</sup> Medicines and Older People – Supplement to the NSF for Older People, 2001.

## Medicines 12.1 Practice guidance

See Medicines 11.1

## Medicines 12.2 Written information

A survey of medication review should be undertaken (Grade A). This could be a computerised search and print out or a survey of 50 records of patients on repeat medication.

## Medicines 12.3 Assessment visit

See Medicines 11.3

## Medicines 12.4 Assessors' guidance

See Medicines 11.4

## Quality and Productivity

	Indicator	Points
QP1	The practice conducts an internal review of their prescribing to assess whether it is clinically appropriate and cost effective, agrees with the PCO three areas for improvement and produces a draft plan for each area no later than 30 June 2011	6
QP2	The practice participates in an external peer review of prescribing with a group of practices and agrees plans for three prescribing areas for improvement firstly with the group and then with the PCO no later than 30 September 2011.	7
QP3	The percentage of prescriptions complying with the agreed plan for the first improvement area as a percentage of all prescriptions in that improvement area during the period 1 January 2012 to 31 March 2012 .  (Payment stages to be determined locally according to the method set out in the indicator guidance below with 20 percentage points between upper and lower thresholds)	5
QP4	The percentage of prescriptions complying with the agreed plan for the second improvement area as a percentage of all prescriptions in that improvement area during the period 1 January 2012 to 31 March 2012 .  (Payment stages to be determined locally according to the method set out in the indicator guidance below with 20 percentage points between upper and lower thresholds)	5
QP5	The percentage of prescriptions complying with the agreed plan for	5

	the third improvement area as a percentage of all prescriptions in that improvement area during the period 1 January 2012 to 31 March 2012 .  (Payment stages to be determined locally according to the method set out in the indicator guidance below with 20 percentage points between upper and lower thresholds)	
<b>QP6</b>	The practice meets internally to review the data on secondary care outpatient referrals provided by the PCO	5
<b>QP7</b>	The practice participates in an external peer review with a group of practices to compare its secondary care outpatient referral data either with practices in the group of practices or with practices in the PCO area and proposes areas for commissioning or service design improvements to the PCO	5
<b>QP8</b>	The practice engages with the development of and follows three agreed care pathways for improving the management of patients in the primary care setting (unless in individual cases they justify clinical reasons for not doing this) to avoid inappropriate referrals and produces a report of the action taken to the PCO no later than 31 March 2012	11
<b>QP9</b>	The practice meets internally to review the data on emergency admissions provided by the PCO	5
<b>QP10</b>	The practice participates in an external peer review with a group of practices to compare its data on emergency admissions either with practices in the group of practices or practices in the PCO area and proposes areas for commissioning or service design improvements to the PCO	15
<b>QP11</b>	The practice engages with the development of and follows three agreed care pathways (unless in individual cases they justify clinical reasons for not doing this) in the management and treatment of patients in aiming to avoid emergency admissions and produces a report of the action taken to the PCO no later than 31 March 2012	27.5

## Quality and productivity (QP) indicator 1

The practice conducts an internal review of their prescribing to assess whether it is clinically appropriate and cost effective, agrees with the PCO three areas for improvement and produces a draft plan for each area no later than 30 June 2011. For Scotland, if the data is not available to allow 3 areas to be agreed by 30 June 2011, then the 3 areas must be agreed within 8 weeks of receipt of the data.

### Quality and productivity 1.1 Practice guidance

The PCO must provide practices with data on their prescribing and comparisons with other practices in the PCO area and nationally to enable practices to review the clinical appropriateness and cost effectiveness of their prescribing. The data may include levels of prescribing of drugs available generically and information about the costs of drugs actually prescribed and clinically suitable lower cost alternatives. All prescribers in the practice will meet to review and reflect on the practice's prescribing

performance with regard to clinical appropriateness and cost effectiveness, taking account of the information supplied by the PCO. For Scotland, a majority of prescribers will participate in the internal review. This is to allow for portfolio working, annual leave and sickness absence.

Using this data, practices will identify three areas of prescribing for improvement in order to bring about more clinically appropriate and cost effective prescribing. The areas must not be the same as those agreed for the Medicines 6 and Medicines 10 QOF indicators. Having identified the three improvement areas the practice will identify plans for improvement which respond to their local circumstances, focusing on those individual areas of expenditure which are significant throughout the year and which offer the greatest opportunity for improved clinical effectiveness or productivity savings or both when compared with similar practices. For Scotland, in order to determine performance against these 3 indicators, practice achievement in these areas will for practices be measured against national prescribing data provided to Health Boards by Information Services Division of NHS NSS. Practices may as an alternative agree to be measured against locally generated performance data provided this is agreed locally between the practice, the Health Board and the LMC.

The internal review must be completed as early in the year as possible but no later than 30 June 2011. For Scotland, if the data is not available to allow the internal review to be completed by 30 June 2011, then the internal review must be completed within 8 weeks of receipt of the data.

## **Quality and productivity 1.2 Reporting and verification**

The practice produces a report detailing that an internal review has taken place involving all the prescribers in the practice. The report must include a summary of the discussions that have taken place and which three improvement areas have been identified. The three areas must be agreed with the PCO in writing no later than 30 June 2011. For Scotland, if the data is not available to allow 3 areas to be agreed in writing by 30 June 2011, then the 3 areas must be agreed in writing within 8 weeks of receipt of the data.

## **Quality and Productivity (QP) indicator 2**

The practice participates in an external peer review of prescribing with a group of practices and agrees its proposed plans for three prescribing areas for improvement firstly with the group and then with the PCO no later than 30 September 2011. For Scotland, Health Boards in association with the LMC should locally agree the external prescribing review process. The practice participates in an external peer review of their prescribing with a group of practices; this should include their proposed plans for three prescribing areas for improvement that have been previously agreed with the PCO.

## **Quality and productivity 2.1 Practice guidance**

The practice will identify a group of practices with which it will carry out external review of their prescribing. The group must contain a minimum of six practices,

unless the PCO otherwise agrees having due regard to local geography and the historical groupings of practices. For Scotland, practice groupings will be agreed between the Health Board and LMC and each practice will be represented by at least one GP.

The external peer review must consist of a comparison of prescribing behaviour against other practices that have been identified within the group.

In developing the improvement plans, practices in the group must define a numerator and denominator to measure achievement for QP3-5 respectively. The group must also agree the minimum and maximum percentages for payment according to the methodology for QP3-5 described below.

Each practice within the group will present a plan for improvement in each of the three improvement areas which will be reviewed and either agreed or amended by the group. The plans will then be submitted to the PCO for consideration and decision on whether to agree them. The plans will describe how achievement for each of the three areas will be measured.

In order for practices to be given as much time as possible to work on achieving their agreed plans, the group of practices and PCO sign off must be completed as early in the year as possible but no later than 30 September 2011. For Scotland, Health Boards in association with the LMC should locally agree the external prescribing review process. The practice participates in an external peer review of their prescribing with a group of practices; this should include their proposed plans for three prescribing areas for improvement that have been previously agreed with the PCO.

## **Quality and productivity 2.2 Reporting and verification**

The practice produces a report detailing that an external review has taken place involving the practices in the group. The report must include a summary of the discussions that have taken place during the review meetings, which practices have been involved and the three improvement plans that have been agreed with the group of practices. The three areas and plans for improvement must be agreed with the PCO in writing no later than 30 September 2011. For Scotland, Health Boards in association with the LMC should locally agree the external prescribing review process. The practice participates in an external peer review of their prescribing with a group of practices; this should include their proposed plans for three prescribing areas for improvement that have been previously agreed with the PCO.

## **Quality and Productivity (QP) indicator 3**

The percentage of prescriptions complying with the agreed plan for the first improvement area as a percentage of all prescriptions in that improvement area during the period 1 January 2012 to 31 March 2012 .

## **Quality and productivity 3.1 Practice guidance**

Achievement will be assessed at practice level and based on individual practice performance against the agreed plan, and will not be affected by the results of other practices in the group.



In each improvement area there will be an intention to change prescribing behaviour so that the percentage of prescriptions which comply with the plan increases as a percentage of all prescriptions in that area.

## **Quality and productivity 3.2 Reporting and verification**

The definition of the denominator and the numerator for the assessment must be agreed by the PCO with the practice as part of the plan for that improvement area agreed no later than 30 September 2011. For Scotland, Health Boards will agree with the LMC the definition of the denominator and the numerator for the assessment with appropriate timing. As with other parts of the Organisational Domain, exception reporting will not apply.

Achievement will be measured in the final quarter of the 2011/12 year (1 January to 31 March 2012) using ePACT <sup>(161)</sup> data and the number of prescriptions means the number of prescription items.

For Scotland, PRISMS data for the final quarter of the 2011/12 year will be used for achievement. In addition if by agreement with the LMC it may be appropriate to look at Defined Daily Dose instead of or in addition to items dispensed. In exceptional circumstances the LMC and Health Board may choose to look at a non numerical quality indicator such as an audit, and in this circumstance the achievement will be agreed by the Health Board and the practice.

Achievement will be measured against a sliding scale between minimum and maximum percentages.

The maximum percentage will be set locally and should normally be set at the 75th centile of achievement nationally for the quarter ending on 31 December 2010 measured on ePACT against the same definitions of numerator and denominator. The maximum threshold may not be set higher than this but the PCO may agree to set it lower in the light of local circumstances (for example relevant characteristics of the practice population such as a high proportion of patients with intolerance to certain products). The minimum percentage will be set at 20 percentage points lower than the upper threshold. For Scotland, the baseline data will be collected from PRISMS from the last quarter of the 2010/11 year, i.e. quarter ending 31<sup>st</sup> March 2011, to allow like quarter for quarter comparison.

The minimum percentage represents the start of the scale and has a value of zero points. The maximum percentage is the lowest percentage in order to qualify for all of the points in respect of that indicator. If a contractor has achieved a percentage score that is between the minimum and maximum set, it achieves a proportion of the points available in relation to the indicator. The proportion is calculated as follows.

Once the percentage the contractor has scored has been calculated (A), subtract from this the minimum percentage set for the indicator (B), then divide the result by the maximum (C) and minimum (B) percentage scores for the indicator, and multiply the result of that calculation by the total number of points available in relation to the indicator (D). This can be expressed as:

---

<sup>(161)</sup> ePACT is a service provided by the NHS Business Services Authority which enables on line analysis of NHS prescribing data <http://www.nhsbsa.nhs.uk/815.aspx>

(A-B) x D

(C-B)

The PCO will provide the practice with data on achievement against the plan from 1 October 2011 on a monthly basis if possible broken down to individual prescriber. For Scotland, monthly data three months in arrears will be available through PRISMS.

## **Quality and Productivity (QP) indicator 4**

The percentage of prescriptions complying with the agreed plan for the second improvement area as a percentage of all prescriptions in that improvement area during the period 1 January 2012 to 31 March 2012 .

### **Quality and productivity 4.1 Practice guidance**

See Quality and productivity 3.1.

### **Quality and productivity 4.2 Reporting and verification**

See quality and productivity 3.2.

## **Quality and Productivity (QP) indicator 5**

The percentage of prescriptions complying with the agreed plan for the third improvement area as a percentage of all prescriptions in that improvement area during the period 1 January 2012 to 31 March 2012 .

### **Quality and productivity 5.1 Practice guidance**

See Quality and productivity 3.1

### **Quality and productivity 5.2 Reporting and verification**

See Quality and productivity 3.2.

## **Quality and productivity (QP) indicator 6**

The practice meets internally to review the data on secondary care outpatient referrals provided by the PCO.

### **Quality and productivity 6.1 Practice guidance**

The PCO must provide practices with data on secondary care referrals which the practice reasonably requires to conduct the review. Practices should discuss with their PCO what data are required for the practice meeting and when.

Clinicians in the practice will meet at least once during the year to carry out the internal review. This meeting should involve the range of clinicians working within the practice.

At the meeting the practice identifies any apparent anomalies in referral patterns and discuss the reasons why this might be the case. Practices should compare the referral patterns with reference to existing care pathways in order to identify areas where improvement might be made to decision making on referrals. The output of this review must be made available to the group of practices taking part in the external peer review.

## **Quality and productivity 6.2 Reporting and verification**

The practice produces a report summarising the discussions that have taken place at the meeting. This report should be submitted to the PCO no later than 31 March 2012. For Scotland, the report must be submitted to the Health Board by 15 March 2012.

## **Quality and productivity (QP) indicator 7**

The practice participates in an external peer review with a group of practices to compare its secondary care outpatient referral data either with practices in the group of practices or with practices in the PCO area and proposes areas for commissioning or service design improvements to the PCO.

## **Quality and productivity 7.1 Practice guidance**

The practice will identify a group of practices with which it will carry out an external review of their secondary care outpatient referrals. The group must contain a minimum of six practices that share similar referral routes (i.e. refer patients to a similar set of services). For Scotland, practice groupings will be agreed between the Health Board and LMC and each practice will be represented by at least 2 representatives one of whom must be a GP.

The external review must consist of a comparison of the practice data with comparable data from the practices in the group or from all practices in the PCO area to determine why there are any variances and where it may be appropriate for the practice to amend current arrangements for the management of hospital referrals. The focus of review will be to reflect on referral behaviour and whether clinicians can learn from the data to improve how they refer and if they can reduce unnecessary hospital attendances either by following existing care pathways more closely or through the use of alternative care pathways. For Scotland, Health Boards will facilitate external reviews to take place by 30 September 2011 or 5 months after data is received, whichever is the earlier.

Following the review, the practice should propose areas for commissioning or service design improvement to the PCO.

## **Quality and productivity 7.2 Reporting and verification**

The practice produces a report detailing that an external review has taken place involving the practices in the group. The report must include a summary of the discussions that have taken place during the review meetings, which practices have been involved and what areas have been proposed for commissioning or service design improvement. The report must be submitted to the PCO no later than 31 March 2012. For Scotland, the report must be submitted to the Health Board by 15 March 2012

## **Quality and productivity (QP) indicator 8**

The practice engages with the development of and follows three agreed care pathways for improving the management of patients in the primary care setting (unless in individual cases they justify clinical reasons for not doing this) to avoid inappropriate

referrals and produces a report of the action taken to the PCO no later than 31 March 2012. For Scotland, the report must be submitted to the Health Board by 15 March 2012.

### **Quality and productivity 8.1 Practice guidance**

It is expected that PCOs will lead the development of care pathways as defined above, working with practice groups. For Scotland, the secondary outpatient referral pathways to be agreed and followed will be chosen at the level of the NHS Board, with Boards making initial proposals to LMCs for discussion and agreement.

GPs in the practice must actively respond to the care pathway development process for the purpose of this indicator. This may, for example, involve attending meetings with other health professionals concerned with the care pathway or commenting to the pathway group electronically. The three care pathways cannot be the same as those identified for indicator QP11. Where possible, the focus of the care pathways should be on long term conditions.

Practices must then follow the agreed care pathways in the treatment of their patients, unless in individual cases they can justify clinical reasons for not doing this.

## **Quality and productivity 8.2 Reporting and verification**

The practice produces a report summarising the action taken, information about which care pathways were followed and changes in the patterns of referral that have resulted. This report should be submitted to the PCO by 31 March 2012. For Scotland, the report must be submitted to the Health Board by 15 March 2012.

Achievement will be awarded on the basis that practices have both engaged in the development of care pathways and delivered care along the agreed care pathways.

It is expected that a practice will follow the agreed care pathways for all patients. However, it is recognised that it may not be clinically appropriate for every patient, for example not all patients may be able to tolerate certain drugs. In these circumstances the report should show that the practice has considered following the care pathway in treating these patients and has documented reasons why it is not clinically appropriate in those individual circumstances. For Scotland, the report will include overview and learning from a reflective analysis of 1 per 1000 registered patients up to a maximum of 5 patients referred along each of three pathways in the year up until 31 December 2011.

## **Quality and productivity (QP) indicator 9**

The practice meets internally to review the data on emergency admissions provided by the PCO.

### **Quality and productivity 9.1 Practice guidance**

The PCO must provide practices with data on emergency admissions which the practice reasonably requires to conduct the review. Practices should discuss with their PCO what data are required for the practice meeting and when.

Clinicians in the practice will meet at least once during the year to carry out the internal review. This meeting should involve the range of clinicians working within the practice.

Emergency admissions are defined as admissions that are unpredictable and at short notice because of clinical need <sup>(162)</sup>.

Practices should explore the reasons for emergency admissions with reference to available pathways in order to identify areas where improvement might be made. The output of this review must be made available to the group of practices taking part in the external peer review. For Scotland, internal reviews will take place by 30 June 2011. If data not available to allow internal review to take place by 30<sup>th</sup> June 2011, the internal review will take place within 8 weeks of receipt of the data.

---

<sup>(162)</sup> NHS Data Dictionary – Admission method codes 21, 22, 23, 24 and 28  
[http://www.datadictionary.nhs.uk/data\\_dictionary/attributes/a/add/admission\\_method\\_de.asp?shownav](http://www.datadictionary.nhs.uk/data_dictionary/attributes/a/add/admission_method_de.asp?shownav)

## **Quality and productivity 9.2 Reporting and verification**

The practice produces a report summarising the discussions that have taken place at the meeting. This report should be submitted to the PCO no later than 31 March 2012. For Scotland, the report must be submitted to the Health Board by 15 March 2012.

## **Quality and productivity (QP) indicator 10**

The practice participates in an external peer review with a group of practices to compare its data on emergency admissions either with practices in the group of practices or practices in the PCO area and proposes areas for commissioning or service design improvements to the PCO.

## **Quality and productivity 10.1 Practice guidance**

The steps outlined in indicator QP7 apply to QP10, with references to “secondary outpatient referrals” replaced with references to “emergency admissions”.

## **Quality and productivity 10.2 Reporting and verification**

The practice produces a report detailing that an external review has taken place involving the practices in the group. The report must include a summary of the discussions that have taken place during the review meetings, which practices have been involved and what areas have been proposed for commissioning or service design improvement. The report must be submitted to the PCO no later than 31 March 2012. For Scotland, the report must be submitted to the Health Board by 15 March 2012.

## **Quality and productivity (QP) indicator 11**

The practice engages with the development of and follows three agreed care pathways (unless in individual cases they justify clinical reasons for not doing this) in the management and treatment of patients in aiming to avoid emergency admissions and produces a report of the action taken to the PCO no later than 31 March 2012. For Scotland, the report must be submitted to the Health Board by 15 March 2012.

## **Quality and productivity 11.1 Practice guidance**

The steps outlined in indicator QP8 apply to indicators QP11, with references to “secondary outpatient referrals” replaced with references to “emergency admissions”.

## **Quality and productivity 11.2 Reporting and verification**

The practice produces a report summarising the action taken, information about which care pathways were followed and changes in the rates of emergency admissions that have resulted. This report should be submitted to the PCO by 31 March 2012. For Scotland, the report must be submitted to the Health Board by 15 March 2012.

Achievement will be awarded on the basis that practices have both engaged in the development and delivered care along the agreed pathways.

It is expected that a practice will follow the agreed care pathways for all patients. However, it is recognised that it may not be clinically appropriate for every patient, for example not all patients may be able to tolerate certain drugs. In these circumstances the report should show that the practice has considered following the care pathway in treating these patients and has documented reasons why it is not clinically appropriate in those individual circumstances.



## Section 4: Patient Experience Domain

Indicator	Points
<p>PE 1. Length of consultations</p> <p>The length of routine booked appointments with the doctors in the practice is not less than 10 minutes. (If the practice routinely sees extras during booked surgeries, then the average booked consultation length should allow for the average number of extras seen in a surgery session. If the extras are seen at the end, then it is not necessary to make this adjustment). For practices with only an open surgery system, the average face to face time spent by the GP with the patient is at least 8 minutes. Practices that routinely operate a mixed economy of booked and open surgeries should report on both criteria.</p>	33

### PE 1 Length of consultations

The length of routine booked appointments with the doctors in the practice is not less than ten minutes. If the practice routinely sees extras during booked surgeries, then the average booked consultation length should allow for the average number of extras seen in a surgery session. If the extras are seen at the end, then it is not necessary to make this adjustment.

For practices with only an open surgery system, the average face to face time spent by the GP with the patient is at least eight minutes.

Practices that routinely operate a mixed economy of booked and open surgeries should report on both criteria.

#### PE 1.1 Practice guidance

The contract includes an incentive for practices to provide longer consultations. This has been included as a proxy for many of the things that are crucial parts of general practice, yet cannot easily be measured e.g. listening to patients, taking time, involving patients in decisions, explaining treatments, in addition to providing high quality care for the many conditions not specifically included in the QOF.

Practices can claim this payment if their normal booking interval is ten minutes or more. ‘Normal’ means that three quarters or more of their appointments should be ten minutes or longer. Deciding whether a practice meets this requirement depends on the booking system.

#### *Practices with appointment systems*

For practices where three quarters of patients are seen in booked appointments of ten minutes or more, and surgery sessions are not normally interrupted by ‘extras’, the contract requirement is met. Extras seen at the end of surgeries and patients seen in emergency surgeries should then not amount to more than a quarter of patients seen.

If extras are routinely seen during surgeries, this will reduce the effective length of time for consultation. For example, if a surgery session has 12 consultations booked at ten minute intervals, but six extras are routinely added in, then the average time for patients will be  $120/18$  equals 6.7 minutes and these slots would not meet the ten minute requirement. Practices will generally find it easier to decide whether they meet the ‘three quarters’ requirement if extras are seen at the end of routine surgeries, rather than fitted in during them.

Some practices use booking systems which contain a mixture of slots booked at different lengths within a single surgery. In these practices, the overall number of slots which are ten minutes or more in length should be three quarters of the total.

#### *Practices without appointment systems or with mixed systems*

Some practices do not run an appointment system. In this case, or where some surgeries are regularly ‘open’, practices should measure the actual time of consultations in two separate sample weeks during each year. It is not necessary to do this if fewer than a quarter of patients are seen in open surgeries and the rest of the surgeries are booked at intervals of ten minutes or more, as the ‘three quarters’ requirement will already be met.

For practices using computerised clinical systems, the length of consultations can be recorded automatically from the computer, providing the doctors know that it is being used for this purpose during the week. Where actual consultation length is measured, the average time with patients should be at least 7.25 minutes. This assumes that the face to face time has been eight minutes in three quarters of consultations (equivalent to the face to face time in a ten minute booked slot) and five minutes in the remainder.

#### *Unusual systems*

Practices organise consulting in a wide variety of different ways. This guidance covers the majority of systems. However, if the practice believes that the spirit of the indicator is met but that the evidence it can provide is different, it should have discussions with the PCO at an early stage.

#### PE 1.2 Written evidence

For practices where three quarters of patients are seen in booked appointments of ten minutes or more and surgery sessions are not normally interrupted by ‘extras’ the contract requirement is met. Practices should submit a statement to this effect. (Grade A)

For other practices, claiming against this indicator, a survey carried out on two separate weeks of consultation length or a computer printout which details the average consultation length should be available. (Grade A)

#### PE 1.3 Assessment visit

If the practice operates an appointment system, inspection of the appointments book (whether paper or computerised) should be carried out, looking at a sample of days over the preceding year. If the practice has submitted a survey of consultation length, this should be reviewed.

#### PE 1.4 Assessors’ guidance

The assessors may need to look at a number of sample days to confirm that 75 per cent of consultations have been booked at least at ten minute intervals.

If a manual survey of average consultation time has been submitted the assessors should question the clinical and administrative staff on how and when this was carried out.

## Section 5: Additional Services Domain

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

### Cervical screening (CS)

	Indicator	Points
CS 1	The percentage of patients (aged from 25 to 64 in England and Northern Ireland, from 20 to 60 in Scotland and from 20 to 64 in Wales) whose notes record that a cervical smear has been performed in the preceding five years (Payment stages 40–80%)	11
CS 5	The practice has a system for informing all women of the results of cervical smears	2
CS 6	The practice has a policy for auditing its cervical screening service, and performs an audit of inadequate cervical smears in relation to individual smear-takers at least every 2 years	2
CS 7	The practice has a protocol that is in line with national guidance and practice for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate smear rates	7

### Child health surveillance (CHS)

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

### Maternity services (MAT)

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

### Contraception (SH)

	Indicator	Points
--	-----------	--------

SH 1	The practice can produce a register of women who have been prescribed any method of contraception at least once in the last year, or other appropriate interval e.g. last 5 years for an IUS.	4
SH 2	The percentage of women prescribed an oral or patch contraceptive method who have also received information from the practice about long acting reversible methods of contraception in the preceding 15 months (Payment stages 40–90%)	3
SH 3	The percentage of women prescribed emergency hormonal contraception at least once in the year by the practice who have received information from the practice about long acting reversible methods of contraception at the time of, or within one month of, the prescription (Payment stages 40–90%)	3

## Cervical screening (CS)

### CS indicator 1

The percentage of patients (aged from 25 to 64 in England and Northern Ireland, from 20 to 60 in Scotland and from 20 to 64 in Wales) whose notes record that a cervical smear has been performed in the preceding 5 years.

### CS 1.1 Practice guidance

This indicator reflects the previous target payment system for cervical screening and is designed to encourage and incentivise practices to continue to achieve high levels of uptake in cervical screening.

The practice should provide evidence of the number of eligible women aged, from 25 to 64 in England and Northern Ireland, from 20 to 60 in Scotland and from 20 to 64 in Wales, who have had a cervical smear performed in the last 60 months.

This indicator differs from all the other additional service indicators in that a sliding scale will apply between 40 per cent and 80 per cent, in a similar fashion to the clinical indicators.

Exception reporting (as detailed in the clinical section) will apply and specifically includes women who have had a hysterectomy involving the complete removal of the cervix.

#### Exception reporting

From April 2011, the exception reporting rules regarding ‘did not attend’ (DNA) letters for the additional services cervical screening indicators in the QOF have changed. The first two letters from the central cancer screening services inviting a patient to attend for a screening will now count towards the three letters required to code a patient as DNA.

Practices will be responsible for sending out the third letter before a DNA code may be used.

This revised exception reporting criteria is not applicable to practices that have opted to run their own call/recall system. These practices will still be required to issue all three reminder letters directly in order to meet the DNA criteria. Copies of the letters sent by the practice may be required for assessment purposes.

England. NHS Cancer Screening Programme.

<http://www.cancerscreening.nhs.uk/cervical/index.html>

Scotland. Scottish Cervical Call/Recall system (SCCRS). (available (through NHS net only)[www.sccrs.scot.nhs.uk](http://www.sccrs.scot.nhs.uk)

Wales. Cervical Screening Wales. <http://www.screeningservices.org.uk/csw/>

Northern Ireland. The Public Health Agency (PHA) has the lead role in screening in NI. Screening services are jointly commissioned with the Health and Social Care Board (HSCB). The general practice role in screening is through the HSCB.

## **CS 1.2 Written evidence**

There should be a computer print-out showing the number of eligible women on the practice list, the number exception reported and the number who have had a cervical smear performed in the last five years (Grade A). In many areas the PCO may provide these data although, other than patients with hysterectomy, they will be unaware of exceptions, for example patients who have been invited on three occasions but failed to attend or those who have opted out of the screening programme. Practices should remove patients from the denominator in the same way as with the clinical indicators.

## **CS 1.3 Assessment visit**

The print-out should be inspected.

## **CS 1.4 Assessors' guidance**

The assessors should enquire on how patients who are exception-reported are identified and recorded.

## **CS indicator 5**

The practice has a system for informing all women of the results of cervical smears.

## **CS 5.1 Practice guidance**

It is generally accepted as good practice for all women who have had a cervical smear performed to be actively informed of the result. Responsibility for the system may be outwith the practice.

## **CS 5.2 Written evidence**

There should be a description of the system and examples of letters sent to patients. (Grade C)

## **CS 5.3 Assessment visit**

The team should be questioned on how women are informed of the way they will obtain the result of their smear.

## **CS 5.4 Assessors' guidance**

A letter sent to the patient containing and explaining the result is ideal.

## **CS indicator 6**

The practice has a policy for auditing its cervical screening service, and performs an audit of inadequate cervical smears in relation to individual smear takers at least every two years.

## **CS 6.1 Practice guidance**

In this audit the criteria, the results, analysis of results, corrective action, the results of the re-audit and a discussion of them needs to be presented. The standard or level of performance against which the criterion is judged would usually involve looking for smear takers who are obvious outliers in relation to the reading laboratory's average for inadequate smears.

## **CS 6.2 Written evidence**

An audit of inadequate smears should be recorded. (Grade A)

## **CS 6.3 Assessment visit**

A discussion with smear takers should take place, dealing with the audit and any educational needs which arose and how these were met.

## **CS 6.4 Assessors' guidance**

All the elements for an audit stated in the practice guidance need to be present.

## **CS indicator 7**

The practice has a protocol that is in line with national guidance and practice for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate smear rates.

## **CS 7.1 Practice guidance**

If a robust system for the management of cervical screening is not in place then this is an area of great risk for general practice. The policy may have been drawn up outwith the practice and should be in line with national guidance.

See guidance on DNA letters in section CS1.1 practice guidance.

## **CS 7.2 Written evidence**

There should be a written policy covering the issues outlined above. (Grade A)

## **CS 7.3 Assessment visit**

The policy should be discussed with relevant staff and the practice should demonstrate how the systems operate.

## **CS 7.4 Assessors guidance**

It may be necessary to ask the practice to demonstrate how its policy operates.

## **Child health surveillance (CHS)**

### **CHS indicator 1**

Child development checks are offered at intervals that are consistent with national guidelines and policy.

### **CHS 1.1 Practice guidance**

The child health surveillance programme should be based on national guidelines <sup>(163)</sup>. It is important that the practice has a system to ensure follow-up of any identified concern and that referrals are made as appropriate <sup>(164)</sup>.

Guidance on Implementation in Scotland. Health for All Children 4 (Hall 4): <http://www.scotland.gov.uk/Publications/2005/04/15161325/13269>

### **CHS 1.2 Written evidence**

There should be a description of the child health surveillance programme and how concerns are followed up. (Grade C)

---

<sup>(163)</sup> Healthy Child Programme (2009). Pregnancy and the first five years of life. [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_107563](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107563)

<sup>(164)</sup> Hall, D. and Elliman D. (2003) eds Health for all children (fourth ed) Oxford University Press



### **CHS 1.3 Assessment visit**

The practice team is asked for details of child health surveillance in the practice and how concerns are followed up.

### **CHS 1.4 Assessors' guidance**

The practice should be aware of which guidelines it has adopted. The assessors should be content that there is a process to ensure concerns are followed up.

## **Maternity services (MAT)**

### **MAT indicator 1**

Ante-natal care and screening are offered according to current local guidelines.

#### **MAT 1.1 Practice guidance**

Most local areas have produced guidelines, which should be adopted within the practice.

#### **MAT 1.2 Written evidence**

There should be written guidelines on ante-natal care and screening. (Grade A)

#### **MAT 1.3 Assessment visit**

The assessment should involve a description of ante-natal care, using the illustration of one case.

#### **MAT 1.4 Assessors' guidance**

The case should show that the guidance is known and is being used.

## **Contraception (SH)**

Around 80 per cent of (prescribed) contraception in the UK is provided in general practice.

The vast majority of practices are providing the additional service for contraception and many are also providing enhanced services including long acting reversible contraception (LARC) methods. All practices providing any level of contraception need to be able to advise women about all methods to ensure they can make an informed choice. Clinical staff in practices which are not providing all methods also need enough knowledge of these to refer appropriately those women who have chosen a method which they do not supply. Practices also should be aware of local services and local referral pathways.

Sexual Health Strategy for Scotland. Respect & Responsibility.

<http://www.scotland.gov.uk/Resource/Doc/35596/0012575.pdf>

NHS Quality Improvement Scotland Sexual Health Services (2008). Standards.

[http://www.nhshealthquality.org/nhsqis/files/SEXHEALTHSERV\\_STANF\\_MA\\_R08.pdf](http://www.nhshealthquality.org/nhsqis/files/SEXHEALTHSERV_STANF_MA_R08.pdf)

This indicator set seeks to increase the awareness of women seeking contraceptive advice in general practices of LARC methods and thus to increase the percentage of women using these methods<sup>(165)</sup>.

## **Contraception (SH) indicator 1**

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

### **SH 1.1 Rationale**

General practices provide 80 per cent of prescribed contraception in the UK. This register is applicable to all methods of contraception that have been prescribed by the practice:

- Emergency hormonal contraception
- Combined oral contraception
- Progestogen only oral contraception
- Contraceptive patch
- Contraceptive diaphragm
- Intrauterine device (IUD)
- Intrauterine system (IUS)
- Contraceptive implant

Any woman who has been prescribed any method at least once in the last year (or the appropriate prescribing interval for method of choice) should be included on the register.

This indicator is prospective from 1 April 2009.

### **SH 1.2 Reporting and verification**

The practice reports the number of women prescribed any method of contraception in the preceding 1 April to 31 March (or longer if appropriate for the method of choice).

---

<sup>(165)</sup> See also J Fam Plann Reprod Health Care 2008; 34(4): 000–000 “Attitudes of women in Scotland to contraception: a qualitative study to explore acceptability of long-acting methods” Anna Glasier, Jane Scorer, Alison Bigrigg.

## Contraception (SH) indicator 2

The percentage of women prescribed an oral or patch contraceptive method who have also received information from the practice about long acting reversible methods of contraception in the preceding 15 months.

### SH 2.1 Rationale

A woman's contraceptive needs can change over her reproductive lifespan. Women requiring contraception should be given detailed information about and offered a choice of all methods, including LARC. This indicator seeks to encourage practices to review these needs on a regular basis and ensure that women are informed of advances in contraceptive choices.

All currently available long acting reversible contraception methods (LARC) are more cost-effective than the combined oral contraceptive even at one year of use. LARC methods include intrauterine devices, the intrauterine system, injectable contraceptives and implants. This is largely because their effectiveness is independent of patient compliance. Of the LARC methods, injectable contraceptives are the least cost-effective. Increasing the uptake of LARC methods will reduce the number of unintended pregnancies. However, currently in the UK, about eight per cent of contraceptive users use LARC. Whilst international comparison is difficult, this percentage is very low.

NICE clinical guideline 30 (2005). Guidance on LARCs.

<http://www.nice.org.uk/Guidance/CG30>

Information from the practice should be written and verbal. Leaflets can be obtained from a number of sources including the fpa, a UK-wide sexual health charity, which produces an excellent range of contraception leaflets including 'Your Guide to Contraception', which, amongst other things, indicates LARC and non-LARC methods clearly through the use of shading.

See <http://www.fpa.org.uk/Information/Readourinformationbooklets/guide>

Faculty of Sexual & Reproductive Healthcare guidelines on contraceptive methods are available at [www.ffprhc.org.uk](http://www.ffprhc.org.uk).

### SH 2.2 Reporting and verification

The practice reports the percentage of those women prescribed oral or transdermal contraception who have a record of having been given advice on LARC methods in the preceding 15 months.

Verification - practices should be prepared to demonstrate how patients are given such advice, examples of leaflets and any specific practice protocols.

## Contraception (SH) indicator 3

The percentage of women prescribed emergency hormonal contraception at least once in the last year by the practice, who have received information from the practice about long-acting reversible methods of contraception at the time of, or within one month of the prescription.

### **SH 3.1 Rationale**

Women requiring emergency hormonal contraception should be given detailed information about and offered a choice of all methods, including LARC. It is often possible (and in many cases ideal practice) to commence an ongoing method of contraception at the same time as emergency hormonal contraception is given.

Some women seeking emergency contraception may be best served by being offered an emergency IUD. Emergency IUDs offer a slightly longer window period for action after unprotected intercourse than hormonal EC; they have a higher efficacy in prevention of pregnancy - and they provide excellent ongoing contraception if required.

Information from the practice should be written and verbal. Leaflets can be obtained from a number of sources however the fpa, a UK-wide sexual health charity, has an excellent range of contraception leaflets including 'Your Guide to Contraception', which, amongst other things, indicates LARC and non-LARC methods clearly through the use of shading.

### **SH 3.2 Reporting and verification**

The practice reports the percentage of those women prescribed emergency hormonal contraception who are recorded as having received advice on LARC methods at the time of, or within one month of the most recent script for emergency hormonal contraception.

## Glossary of terms

Abbreviation	Definition
ACCORD	Action to Control Cardiovascular Risk in Diabetes
ACE	Angiotensin-Converting Enzyme
ACE-I	Angiotensin-Converting Enzyme Inhibitor
ACR	Albumin:Creatinine Ratio
ACS	Acute Coronary Syndrome
ACTIVE-W	Atrial Fibrillation Clopidogrel Trial with Irbesartan for Prevention of Vascular Events
ADA	After Death Analysis
AED	Antiepileptic Drugs
AF	Atrial Fibrillation
APHO	Association of Public Health Observatories
ARB	Angiotensin Receptor Blocker
BAFTA	<i>Birmingham Atrial Fibrillation Treatment</i> of the Aged
BDI-II	Beck Depression Inventory, second edition
BHSOC	British Hypertension Society
BLS	Basic Life Support
BMI	Body Mass Index
BMA	British Medical Association
BNF	British National Formulary
BP	Blood Pressure
BTS	British Thoracic Society
CABG	Coronary Artery Bypass Grafting
CAD	Coronary Artery Disease
CBT	Cognitive Behavioural Therapy
CHD	Coronary Heart Disease
CKD	Chronic Kidney Disease
COPD	<i>Chronic Obstructive Pulmonary Disease</i>
COSHH	Control of Substances Hazardous to Health
CPA	Care Programme Approach
CT	Computerised Tomography
CVD	Cardiovascular Disease
DAs	Devolved Administrations
DBP	Diastolic Blood Pressure
DH	Department of Health
DM	Diabetes Mellitus
DNA	Did Not Attend
DRS	Diabetic Retinopathy Screening
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, fourth edition
EC	Emergency Contraception
ECG	Electrocardiogram

eGFR	Estimated Glomerular Filtration Rate
EOLC	End of Life Care
EPIC	European Prospective Investigation into Cancer
EPP	Exposure Prone Procedures
FBC	Full Blood Count
FEV <sub>1</sub>	Forced Expiratory Volume in One Second
FVC	Forced Vital Capacity
GFR	Glomerular Filtration Rate
GMP	Good Medical Practice
GMS	General Medical Services
GOLD	The Global Initiative for Chronic Obstructive Lung Disease
GP	General Practitioner
GPC	General Practitioners Committee
GPRD	General Practice Research Database
GPwSI	GP with a Special Interest
GSF	Gold Standards Framework
HAD-D	Hospital Anxiety and Depression Scale Depression Sub-Scale
HADS	Hospital Anxiety and Depression Scale
HbA1c	Glycated Hemoglobin
HCA	Healthcare Assistant
HF	Heart Failure
HSWA	Health and Safety at Work Act
IC	NHS Health and Social Care Information Centre
IGT	Impaired Glucose Tolerance
IFCC	International Federation of Clinical Chemistry and Laboratory Medicine
IUD	Intrauterine Device
IUS	Intrauterine System
JBS	Joint British Societies'
JCVI	Joint Committee on Vaccination and Immunisation
LARC	Long Acting Reversible Contraception
LD	Learning Disability
LVD	Left Ventricular Dysfunction
MCM	Major Congenital Malformation
MH	Mental Health
MI	Myocardial Infarction
MR	Modified Release
MRC	Medical Research Council
MRI	Magnetic Resonance Imaging
NAO	National Audit Office
NHANES	National Health and Nutrition Examination Survey
NHS	National Health Service
NHSE	NHS Employers
NICE	National Institute for Health and Clinical Excellence
NPSA	National Patient Safety Agency

NPV	Negative Predictive Value
NSAIDS	Non-Steroidal Anti-Inflammatory Drugs
NSF	National Service Framework
ONS	Office for National Statistics
OTC	Over The Counter
PCO	Primary Care Organisation
PCR	Protein:Creatinine Ratio
PCT	Primary Care Trust
PEF	Peak Expiratory Flow
PHQ-9	Nine Item Patient Health Questionnaire
PP	Primary Prevention
QMAS	<b><i>Quality Management and Analysis System</i></b>
QOF	Quality and Outcomes Framework
QPA	Quality Practice Award
RCGP	Royal College of General Practitioners
RCTs	Randomised Controlled Trials
SCR	Supportive Care Register
SEA	Significant Event Auditing
SIGN	Scottish Intercollegiate <b><i>Guidelines</i></b> Network
SIMD	Scottish Index of Multiple Deprivation
SMI	Serious Mental Illness
SSRI	Selective Serotonin Reuptake Inhibitors
TIA	Transient Ischemic Attack
TPCR	Total Protein: Creatinine Ratio
TSH	Thyroid Stimulating Hormone
UK	United Kingdom
WHO	World Health Organisation”

## ANNEX F

### CALCULATION OF ADDITIONAL SERVICES ACHIEVEMENT POINTS

F.1 The additional services indicators do not apply to all of the contractor's registered population. Assessment of achievement is carried out in relation to particular target populations. The relevant target populations are–

- Cervical screening services: females aged 21 to 60 years
- Child health surveillance: children of both sexes under the age of 5 years
- Maternity medical services: females aged under 55 years
- Contraceptive services: females aged under 55 years

F.2 For example, to meet the requirements of the child health surveillance indicator, child health development checks will only need to be offered to the practice's registered population of children under the age of 5 years.

F.3 For each of the additional services mentioned in paragraph F.1, a Target Population Factor is to be calculated as follows -

- (a) first the number of patients registered with the contractor in the relevant target population at the start of the final quarter (**A**) is to be divided by the contractor's CRP at the start of the final quarter (**B**);
- (b) then the number of patients registered with all contractors in Scotland in the relevant target population at the start of the final quarter (**C**) is to be divided by the total number of patients registered in Scotland (according to PSD of NHS National Services Scotland) at the start of the final quarter (**D**); and
- (c) the number produced by the calculation in paragraph (a) is then to be divided by the number produced by the calculation in paragraph (b) to produce the Target Population Factor for the additional service in question.

F.4 For the purposes of paragraph F.3, the “relevant date” is the date in respect of which the value of the contractor's CPI that is being used to calculate its Achievement Payment is established. Generally this is the start of the final quarter of the financial year to which the Achievement Payment relates, but see paragraph 6.7.

F.5 The Target Population Factor for the additional service is to be multiplied by £130.38 to produce the cash total in respect of the additional service (**F**).



F.6 This calculation could be expressed as–

$$\frac{(A \div B) \times \pounds 130.38 \times E}{(C \div D)} = F$$

F.7 If the contractor has not been under an obligation to provide an additional service for any period during the financial year to which the Achievement Payment relates, the adjusted total for that particular additional service is to be further adjusted by the fraction produced by dividing–

- (a) the number of days in the financial year during which its GMS contract had effect and the contractor was under an obligation to provide the additional service; by
- (b) the number of days in the financial year during which the contract had effect.

F.8 The resulting cash amounts, in respect of each additional service, are then to be added together for the total amount in respect of the additional services domain.

## ANNEX G

### ADJUSTED PRACTICE DISEASE FACTOR CALCULATIONS

G.1 The calculation involves three steps:

- the calculation of the practice's Raw Practice Disease Prevalences. There will be a Raw Practice Disease Prevalence in respect of each disease area (other than the area relating to palliative care) for which the contractor is seeking to obtain Achievement Points;
- making an adjustment to give an Adjusted Practice Disease Factor (APDF);
- applying the factor to the pounds per point figure for each disease area (other than the area relating to palliative care).

G.2 These steps are explained below.

G.3 The Raw Practice Disease Prevalence is calculated by dividing the number of patients on the relevant disease register at 31st March in the financial year to which the Achievement Payment relates by the contractor's CRP for the relevant date. For these purposes, the "relevant date" is the date in respect of which the value of the contractor's CPI that is being used to calculate its Achievement Payment is established. Generally this is the start of the final quarter of the financial year to which the Achievement Payment relates, but see paragraph 6.7.

G.4 Subject to the provisions at G4A and G4B relating to calculations in respect of Achievement Payments relating to financial years prior to 2010/2011, the Adjusted Practice Disease Factor is calculated by:

- (a) calculating the national range of Raw Practice Disease Prevalences in Scotland (Health Boards are to use the national range established annually through the Quality and Outcomes Framework Management and Analysis System (QMAS)) or QOF Calculator System) and applying the agreed % cut-off at the bottom of the range. Practices below this will be treated as having the same prevalence as the cut-off point; A ZERO % cut-off will apply from 2010/2011 onwards (a 5% cut-off applied prior to 2010/2011).
- (b) once the cut-off has been applied, re-basing the contractor figures around the new national Scottish mean to give the Adjusted Practice Disease Factor (APDF). For example, an APDF of 1.2 indicates a 20% greater prevalence than the mean, in the adjusted distribution. The rebasing ensures that in the period commencing on 1 April 2011 and ending on 31<sup>st</sup> March 2012 the average contractor (i.e. one with an APDF of 1.0) receives £130.38 per point, after adjustment;

- (c) thus, adjusting via the factor the contractor's average pounds per point for each disease, rather than the contractor's points score. For example, a contractor with an APDF of 1.2 for CHD in the period commencing 1<sup>st</sup> April 2011 and ending on 31 March 2012 will receive £156.46 per point scored on the CHD indicators.

G4A In respect of Achievement Payments relating to the period commencing on 1<sup>st</sup> April 2009 and ending on 31<sup>st</sup> March 2010, the Adjusted Practice Disease Factor is calculated by:

- (a) calculating the national range of Raw Practice Disease Prevalances in Scotland ( NHS Boards are to use the national range established annually through the Quality and Outcomes Framework and Analysis System (QMAS) and applying a 5% cut-off at the bottom of the range. Contractors below this will be treated as having the same prevalence as the cut-off point;
- (b) once the cut-off has been applied, re-basing the contractor figures around the new national Scottish mean to give the Adjusted Practice Disease Factor (APDF). For example, an APDF of 1.2 indicates a 20% greater prevalence than the mean, in the adjusted distribution. The rebasing ensures that in the period commencing on 1<sup>st</sup> April 2009 and ending on 31<sup>st</sup> March 2010, the average contractor (i.e. one with an APDF of 1.0) will receive £126.76 after adjustment;
- (c) thus, adjusting via the factor the contractor's average pounds per point for each disease, rather than the contractor's points score. For example, a contractor with an APDF of 1.2 for CHD in the period commencing 1<sup>st</sup> April 2009 and ending on 31<sup>st</sup> March 2010 will receive £152.11 per point scored on the CHD indicators.

G.4B In respect of Achievement Payments relating to financial years prior to 1 April 2009, the Adjusted Practice Disease Factor is calculated by:

- (a) calculating the national range of Raw Practice Disease Prevalences in Scotland ( NHS Boards are to use the national range established annually through the Quality and Outcomes Framework Management and Analysis System (QMAS) and applying a 5% cut-off at the bottom of the range. Contractors below this will be treated as having the same prevalence as the cut-off point.
- (b) once the cut –off has been applied making a square root transformation to all the contractor prevalence figures. This means that the prevalence distribution will be compressed to a narrower range. It will prevent financial destabilisation of those with the lowest prevalence;
- (c) after the transformation, rebasing the contractor figures around the new national Scottish mean to give the Adjusted Practice Disease Factor (APDF). For example, an APDF of 1.2 indicates a 20% greater prevalence than the mean, in the adjusted distribution. The rebasing

ensures that for the period commencing on 1 April 2008 and ending on 31<sup>st</sup> March 2009 the average contractor(i.e. one with an APDF of 1.0) receives £124.64 per point after adjustment;

- (d) thus adjusting via the factor the contractor's average pounds per point for each disease rather than the contractor's points score. For example, a contractor with an APDF of 1.2 for CHD will receive £149.57 per point scored on the CHD indicators.

G.5 As a result of this calculation, each contractor will have a different 'pounds per point' figure for each disease area (other than the area relating to palliative care), and it will then be possible to use these figures to calculate a cash total in relation to the points scored in each disease area (other than the area relating to palliative care).

G.6A This national prevalence figure and range of practice prevalence will be calculated on a Scotland-only basis.

G.6B Subject to paragraphs G4A and G4B, if the contractor's GMS contract terminates before 1<sup>st</sup> January in the financial year to which the Achievement Payment relates the Adjusted Practice Disease Factor to be used in calculating the contractor's Achievement Payment should be the Adjusted Practice Disease Factor calculated for the previous financial year.

G6C Where the GMS contract terminates before 1<sup>st</sup> January in any financial year before 1<sup>st</sup> April 2009, the Adjusted Practice Disease Factor relating to any outstanding Achievement Payments on 1<sup>st</sup> April 2010 shall be calculated in accordance with Paragraph G4A.

G6D Where the GMS contract terminates between the period commencing on 1<sup>st</sup> April 2009 and ending on 1<sup>st</sup> January 2010, the Adjusted Practice Disease Factor relating to any outstanding Achievement Payments on 1<sup>st</sup> April 2010 shall be calculated in accordance with paragraph G4B

G6E If the contractor did not have an Adjusted Practice Disease Factor calculation for the previous financial year, then no Adjusted Practice Disease Factor should be used in calculating the contractor's Achievement Payment for that year.

G7 If, after 31<sup>st</sup> March 2010, the contractor's GMS contract terminates on or after 1<sup>st</sup> January, but before 31<sup>st</sup> March, in the financial year to which the Achievement Payment relates the Adjusted Practice Disease Factor to be used in calculating the contractor's Achievement Payment for that year should be the Adjusted Practice Disease Factor calculated in accordance with paragraphs G1 to G4.

## ANNEX H

### LIST OF PRACTICES FOR WHICH ADDITIONAL PAYMENTS ARE PAYABLE UNDER THE GOLDEN HELLO SCHEME

(This is the 03/04 list, which is due to be updated for 04/05)

#### GP PRACTICES LOCATED ON ISLANDS IN SCOTLAND

Location	Health Board	Practice code	Address			Post code
MAIN	ORKNEY	38008	SCAPA MEDICAL GROUP	NEW SCAPA ROAD	KIRKWALL	KW151BZ
MAIN	ORKNEY	38012	SKERRYVORE PRACTICE	NEW SCAPA ROAD	KIRKWALL	KW151BZ
MAIN	ORKNEY	38027	JOHN STREET	STROMNESS	ORKNEY	KW163AD
MAIN	ORKNEY	38031	DOUNBY	ORKNEY		KW172HT
MAIN	ORKNEY	38046	GREYSTONES	EVIE	ORKNEY	KW172PQ
MAIN	ORKNEY	38051	DAISY VILLA	HOPE	ORKNEY	KW172SN
BRANCH	ORKNEY	38051	HALL	BURRAY	ORKNEY	KW172SS
MAIN	ORKNEY	38065	HEATHERLEA	EDAY	ORKNEY	KW172AB
MAIN	ORKNEY	38070	NEW MANSE	NORTH RONALDSAY	ORKNEY	KW172BE
MAIN	ORKNEY	38084	BRINIAN HOUSE	ROUSAY	ORKNEY	KW172PU
BRANCH	ORKNEY	38084	EGILSAY GERAMOUNT HOUSE	ORKNEY		KW172QD
MAIN	ORKNEY	38099	HOUSE	STRONSAY	ORKNEY	KW172AE
MAIN	ORKNEY	38101	FLEBISTER HOUSE	SANDAY	ORKNEY	KW172BW
MAIN	ORKNEY	38116	ELWICKBANK HOY AND WALLS HEALTH CENTRE	SHAPINSAY	ORKNEY	KW172EA
MAIN	ORKNEY	38121		LONGHOPE	ORKNEY	KW163PA
MAIN	ORKNEY	38135	SPRINGBANK	FLOTTA	ORKNEY	KW163NP
MAIN	ORKNEY	38140	TRENABIE HOUSE	WESTRAY	ORKNEY	KW172DL
BRANCH	ORKNEY	38140	PAPA WESTRAY YELL HEALTH CENTRE	ORKNEY		KW172BU
MAIN	SHETLAND	39015		REAFIRTH	MID YELL	ZE2 9BX
BRANCH	SHETLAND	39015	CULLIVOE	YELL	SHETLAND	ZE2 9BT
BRANCH	SHETLAND	39015	BURRAVOE	YELL	SHETLAND	ZE2 9AY
BRANCH	SHETLAND	39015	NURSES HOUSE WHALSAY HEALTH CENTRE	HUBIE	FETLAR	ZE2 9DJ
MAIN	SHETLAND	39020		SYMBISTER	WHALSAY	ZE2 9PS
BRANCH	SHETLAND	39020	NURSES HOUSE HILLSWICK	SKERRIES	SHETLAND	ZE2 9AS
MAIN	SHETLAND	39034	HEALTH CENTRE BRAE HEALTH CENTRE	WEST AYRE	HILLSWICK	ZE2 9RW
MAIN	SHETLAND	39049	WALLS HEALTH CENTRE	BRAE	SHETLAND	ZE2 9QJ
MAIN	SHETLAND	39053		WALLS	SHETLAND	ZE2 9PS
BRANCH	SHETLAND	39053	SANDNESS	WALLS	SHETLAND	ZE2 9PL
BRANCH	SHETLAND	39053	SCHOOLHOUSE	PAPASTOUR	WALLS	ZE2 9PW
BRANCH	SHETLAND	39053	NURSES HOUSE BIXTER HEALTH CENTRE	FOULA	SHETLAND	ZE2 9PN
MAIN	SHETLAND	39068		BIXTER	SHETLAND	ZE2 9NA

BRANCH	SHETLAND	39068	AITH	BIXTER	SHETLAND	ZE2 9NB
BRANCH	SHETLAND	39068	SKELD	BIXTER	SHETLAND	ZE2 9NL
MAIN	SHETLAND	39072	GORD	LEVENWICK	SHETLAND	ZE2 9HX
BRANCH	SHETLAND	39072	NURSE'S HOUSE	FAIR ISLE	SHETLAND	ZE2 9JU
MAIN	SHETLAND	39087	SCALLOWAY	SHETLAND		ZE1 0UX
BRANCH	SHETLAND	39087	WEISDALE	SHETLAND		ZE2 9LQ
BRANCH	SHETLAND	39087	HAMNOVOE	BURRA	SHETLAND	ZE2 9JY
BRANCH	SHETLAND	39087	WHITENESS	SHETLAND		ZE2 9LY
BRANCH	SHETLAND	39087	BRIDGE END LERWICK HEALTH CENTRE	BURRA	SHETLAND	ZE2 9LE
MAIN	SHETLAND	39091		SOUTH ROAD	LERWICK	ZE1 0RZ
BRANCH	SHETLAND	39091	SANDWICK	SHETLAND		ZE2 9HW
BRANCH	SHETLAND	39091	CUNNINGSBURGH	SHETLAND MONTFIELD LANE		ZE2 9HB
MAIN	SHETLAND	39104	BLOCK 1 UNST HEALTH CENTRE		LERWICK	ZE1 0LF
MAIN	SHETLAND	39161		BALTASOUND	UNST	ZE2 9DY
BRANCH	SHETLAND	39161	SAXAVORD	UNST	SHETLAND	ZE2 9EF
BRANCH	SHETLAND	39161	UYEASOUND BROADFORD MEDICAL CENTRE	UNST	SHETLAND	ZE2 9DL
MAIN	HIGHLAND	55516		HIGH ROAD	BROADFORD SKYE AND LOCHALSH	IV499AA
MAIN	HIGHLAND	55521	TRIEN DUNVEGAN HEALTH CENTRE	CARBOST		IV478ST
MAIN	HIGHLAND	55535	HEALTH CENTRE SLEAT MEDICAL PRACTICE	DUNVEGAN	ISLE OF SKYE	IV558GU
MAIN	HIGHLAND	55540		FERRINDONALD	SLEAT	IV448RF
MAIN	HIGHLAND	55569	CHURCH ROAD PORTREE MEDICAL CENTRE	KYLE OF LOCHALSH		IV408DD
MAIN	HIGHLAND	55573		PORTREE	ISLE OF SKYE	IV519BZ
MAIN	HIGHLAND	55677	GRIANAN BRODICK HEALTH CENTRE	ISLE OF EIGG	LOCHABER	PH424RL
MAIN	AYRSHIRE & ARRAN	80645		BRODICK	ARRAN	KA278AJ
MAIN	AYRSHIRE & ARRAN	80650	LAMLASH	ARRAN		KA278NS
BRANCH	AYRSHIRE & ARRAN	80650	BRODICK CLINIC	INVERCLOY	BRODICK	KA278AJ
BRANCH	AYRSHIRE & ARRAN	80650	VILLAGE HALL WHITING BAY CLINIC	KILMORY	ARRAN	KA278PQ
BRANCH	AYRSHIRE & ARRAN	80650		ARNHALL LODGE	WHITING BAY	KA278PX
MAIN	AYRSHIRE & ARRAN	80664	SHISKINE CLINIC	INGLEWOOD	SHISKINE	KA278EW
BRANCH	AYRSHIRE & ARRAN	80664	VILLAGE HALL	KILMORY	ARRAN	KA278PX
BRANCH	AYRSHIRE & ARRAN	80664	NEWTON ROAD COMMUNITY CENTRE	LOCHRANZA	ARRAN	KA278HQ
BRANCH	AYRSHIRE & ARRAN	80664	10 KELBURN STREET	PIRNMILL	ARRAN	KA278JU
MAIN	ARGYLL & CLYDE	80679		MILLPORT ISLE OF LISMORE		KA280DT
BRANCH	ARGYLL & CLYDE	84006	PUBLIC HALL		ARGYLL	PA345UG
MAIN	ARGYLL & CLYDE	84097	ARINAGOUR	ISLE OF COLL ISLE OF COLONSAY		PA786SY
MAIN	ARGYLL & CLYDE	84129	BENORAN			PA617YW
MAIN	ARGYLL & CLYDE	84331	WINDSOR	MAIN STREET	BOWMORE	PA437JH
MAIN	ARGYLL & CLYDE	84345	GEIRHILDA THE RHINNS MEDICAL CENTRE	BACK ROAD PORT CHARLOTTE	PORT ELLEN	PA427DL
MAIN	ARGYLL & CLYDE	84350	GLENCAIRN GP SURGERY		ISLE OF ISLAY	PA487UD
MAIN	ARGYLL & CLYDE	84383		CRAIGHOUSE	ISLE OF JURA	PA607XG
BRANCH	ARGYLL & CLYDE	84472	ARDMINISH	ISLE OF GIGHA		PA417AB

MAIN	ARGYLL & CLYDE	84504	SALEN SURGERY	PIER ROAD	SALEN AROS	PA726JL
MAIN	ARGYLL & CLYDE	84519	ROCKFIELD ROAD	TOBERMORY	ISLE OF MULL	PA756PN
MAIN	ARGYLL & CLYDE	84523	BUNESSAN	ISLE OF MULL		PA676DG
BRANCH	ARGYLL & CLYDE	84523	ISLE OF IONA			PA766SJ
MAIN	ARGYLL & CLYDE	84646	ROTHESAY HEALTH CENTRE	HIGH STREET	ROTHESAY	PA209JL
MAIN	ARGYLL & CLYDE	84805	BAUGH HOUSE GP SURGERY	SCARINISH	ISLE OF TIREE	PA776UN
MAIN	WESTERN ISLES	90007	GEARRA MOR SURGERY	BORVE	ISLE OF LEWIS	HS2 0RX
BRANCH	WESTERN ISLES	90007	HABOST CLINIC	NESS	ISLE OF LEWIS	HS2 0TG
BRANCH	WESTERN ISLES	90007	SHAWBOST SECONDARY SCHOOL	SHAWBOST	ISLE OF LEWIS	HS2 9BQ
MAIN	WESTERN ISLES	90026	CARLOWAY DISTRICT NURSE'S COTTAGE	ISLE OF LEWIS		HS2 9AG
BRANCH	WESTERN ISLES	90026	STORNOWAY HEALTH CENTRE	BREASCLETE SPRINGFIELD ROAD	ISLE OF LEWIS	HS2 9EF
MAIN	WESTERN ISLES	90031	CEILIDH HOUSE	NORTH TOLSTA	ISLE OF LEWIS	HS2 0NG
BRANCH	WESTERN ISLES	90031	STORNOWAY HEALTH CENTRE	SPRINGFIELD ROAD	STORNOWAY	HS1 2PS
MAIN	WESTERN ISLES	90045	CEILIDH HOUSE ARCHWAY	NORTH TOLSTA	ISLE OF LEWIS	HS2 0NG
BRANCH	WESTERN ISLES	90045	MEDICAL PRACTICE	16 FRANCIS STREET	STORNOWAY	HS1 2XB
MAIN	WESTERN ISLES	90064	MIAVAIG THE NURSE'S COTTAGE	VIG	ISLE OF LEWIS	HS2 9HW
BRANCH	WESTERN ISLES	90064	GLEANN MOR BREASCLETE PRIMARY SCHOOL	BREASCLETE	ISLE OF LEWIS	HS2 9LT
MAIN	WESTERN ISLES	90079	BALALLAN PRIMARY SCHOOL	LOCHS	ISLE OF LEWIS	HS2 9JP
BRANCH	WESTERN ISLES	90079	BLAR MHOR	BREASCLETE	ISLE OF LEWIS	HS2 9ED
BRANCH	WESTERN ISLES	90079	DOCTOR'S HOUSE	BALALLAN	ISLE OF LEWIS	HS2 9PN
MAIN	WESTERN ISLES	90083	THE CLINIC	GRAVIR	ISLE OF LEWIS	HS2 9QX
MAIN	WESTERN ISLES	90098	FERRY ROAD	TARBERT	HARRIS	HS3 3BG
BRANCH	WESTERN ISLES	90098	LOCH HOUSE SURGERY	SCALPAY		HS4 3XU
MAIN	WESTERN ISLES	90101	LOCHMADDY	LEVERBURGH		HS5 3UA
BRANCH	WESTERN ISLES	90101	**ALL MAIL TO BE SENT TO THE MAIN PRACTI	GEOCRAB	HARRIS	HS3 3HB
MAIN	WESTERN ISLES	90115	**ALL MAIL TO BE SENT TO THE MAIN PRACTI	NORTH UIST		HS6 5AE
BRANCH	WESTERN ISLES	90115	**ALL MAIL TO BE SENT TO THE MAIN PRACTI	**AT THE SURGERY, LOCHMADDY HS6 5AE**	**AND NOT TO BAYHEAD, TIGH CEILIALA**	
BRANCH	WESTERN ISLES	90115	**ALL MAIL TO BE SENT TO THE MAIN PRACTI	**AT THE SURGERY, LOCHMADDY HS6 5AE**	**AND NOT TO BERNARAY NURSES COTTAGE**	
BRANCH	WESTERN ISLES	90115	**ALL MAIL TO BE SENT TO THE MAIN PRACTI	**AT THE SURGERY, LOCHMADDY HS6 5AE**	**AND NOT TO TRIANAID, CARINISH**	
MAIN	WESTERN ISLES	90120	SORELLE LODGE SURGERY	GRIMINISH	BENBECULA	HS7 5QA
BRANCH	WESTERN ISLES	90120	DALIBURGH HOSPITAL	DALIBURGH	SOUTH UIST	HS8 5SS
BRANCH	WESTERN ISLES	90120	BENBECULA COMMUNITY CLINIC	BALIVANICH	BENBECULA	HS7 5LA

MAIN	WESTERN ISLES WESTERN ISLES	90134	SOUTH UIST MEDICAL PRACTICE	DALIBURGH	LOCHBOISDALE	HS8 5SS
BRANCH	WESTERN ISLES WESTERN ISLES	90134	ERISKAY COMMUNITY CENTRE	SOUTH VIST	SOUTH UIST	HS8 5JU
BRANCH	WESTERN ISLES WESTERN ISLES	90134	CLACH MHILE SURGERY	STONEYBRIDGE	SOUTH UIST	HS8 5SD
MAIN	WESTERN ISLES WESTERN ISLES	90149	CHURCH HALL	CASTLEBAY	ISLE OF BARRA	HS9 5XD
BRANCH	WESTERN ISLES WESTERN ISLES	90149		NORTHBAY	BARRA	HS9 5YQ



# ANNEX I

## PNEUMOCOCCAL AND HIB/MENC BOOSTER VACCINATIONS AND PNEUMOCOCCAL CATCH-UP CAMPAIGN

THE PROVISIONS SET OUT BELOW ARE THE PROVISIONS CONTAINED IN ANNEX 1 AND ANNEX 2 TO THE LETTER DATED 12<sup>TH</sup> JULY 2006 FROM THE CHIEF MEDICAL OFFICER, THE CHIEF NURSING OFFICER AND THE CHIEF PHARMACEUTICAL OFFICER

### Annex 1

#### The Routine Childhood Immunisation Programme

##### 1. Background to the changes

The background for the changes to the routine childhood immunisation programme is detailed in our letter dated 8 February 2006 (available at [http://www.show.scot.nhs.uk/sehd/cmo/CMO\(2006\)03.pdf](http://www.show.scot.nhs.uk/sehd/cmo/CMO(2006)03.pdf)). Further information will be available in the factsheets and new green book chapters, on the NHS Health Scotland website [www.healthscotland.com/immunisation](http://www.healthscotland.com/immunisation) and on the JCVI website [www.advisorybodies.doh.gov.uk/JCVI/](http://www.advisorybodies.doh.gov.uk/JCVI/).

##### 2. Timing

The routine programme will change on 4 September 2006. All children starting their immunisation from that date should be offered the new immunisation schedule. The Hib/MenC booster should also be introduced for children aged 12 months of age from that date.

##### 3. Routine Childhood Immunisation Schedule

All children starting the immunisation programme at 2 months of age will follow the schedule below (see Table 1):

Table 1

When to immunise	What is given	Vaccine and how it is given
Two months old	Diphtheria, tetanus, pertussis, polio and <i>Haemophilus influenzae</i> type b (DTaP/IPV/Hib)	One injection (Pediace)l
	Pneumococcal (PCV)	One injection (Prevenar)
Three months old	Diphtheria, tetanus, pertussis, polio and <i>Haemophilus influenzae</i> type b (DTaP/IPV/Hib)	One injection (Pediace)l
	Meningitis C (MenC)	One injection (Menjugate, Neisvac C or Meningitec)
Four months old	Diphtheria, tetanus, pertussis, polio and <i>Haemophilus influenzae</i> type b (DTaP/IPV/Hib)	One injection (Pediace)l

	Pneumococcal (PCV)	One injection (Prevenar)
	Meningitis C (MenC)	One injection (Menjugate, Neisvac C or Meningitec)
Around 12 months	<i>Haemophilus influenzae</i> type b, Meningitis C (Hib/MenC)	One injection (Menitorix)
Around 13 months	Measles, mumps and rubella (MMR)	One injection (Priorix or MMR II)
	Pneumococcal (PCV)	One injection (Prevenar)
Three years four months to five years old	Diphtheria, tetanus, pertussis and polio (dTaP/IPV or DTaP/IPV)	One injection (Infanrix-IPV or Repevax)
	Measles, mumps and rubella (MMR)	One injection (Priorix or MMR II)
Thirteen to 18 years old	Tetanus, diphtheria and polio (Td/IPV)	One injection (Revaxis)

It is important that all those involved in immunisations are familiar with the childhood immunisation schedule (described in Table 1). Changes are:

- the addition of a pneumococcal conjugate vaccine (PCV) at 2, 4 and 13 months of age;
- one dose of MenC vaccine at 3 and at 4 months;
- a booster dose of Hib and MenC vaccine (given as a combined Hib/MenC vaccine) at 12 months of age.

Introducing these changes means that:

- infants will be offered different combinations of vaccines at the 2, 3 and 4 month visits;
- three injections will be offered to infants at 4 months of age;
- a new 12 month vaccination visit will be introduced.

#### **4. Children aged over 2 months of age at the start of the programme**

There will be a small number of children who will be part-way through their primary vaccination schedule when the changes are introduced. It is important to ensure that these children receive three doses of DTaP/IPV/Hib (Pediacef), and at least two doses of MenC (with one dose being given at the 4 month visit).

All children aged over 2 months and under 2 years of age will be offered PCV as part of the catch-up campaign (see Annex 2 and 3 for details).

All children, irrespective of their primary vaccination history, should receive a booster dose of Hib/MenC vaccine at their routine 12 months of age visit in order to ensure long-term protection. There is no Hib/MenC catch-up for children older than 12 months of age at the start of the new programme.

#### **5. Children at an increased risk of pneumococcal infection**

Some groups of children are at increased risk from pneumococcal infection (see Table 2).

All at-risk children will routinely be offered PCV vaccine, according to the schedule for the routine immunisation programme (i.e. at 2, 4 and 13 months of age). In addition, all at-risk children should be offered a single dose of pneumococcal polysaccharide vaccine (PPV) when they are two years of age or over.

#### At-risk children presenting late for immunisation

At-risk children who present late for vaccination should be offered 2 doses of PCV<sup>166</sup> before the age of 12 months and a further dose at 13 months of age. All at-risk children should also be offered a single dose of PPV when they are two years of age or older and at least 2 months after the final dose of PCV.

At-risk children aged over 12 months and under 5 years of age should be offered a single dose of PCV. Please note that children in this age group who have asplenia or splenic dysfunction, or who are immunocompromised, require a second dose of PCV because this group may have a sub-optimal immunological response to the first dose of vaccine. This should be given 2 months after the first dose. They should also be offered a single dose of PPV (if not previously given) when they are two years of age or older (and at least 2 months after the final dose of PCV).

At-risk children presenting for first pneumococcal immunisation aged 5 years and over should be offered a single dose of PPV.

#### **6. Children under five years of age who have previously had invasive pneumococcal disease**

All children under 5 years of age, who have had invasive pneumococcal disease (IPD), for example pneumococcal meningitis or pneumococcal bacteraemia, should be offered a dose of PCV irrespective of previous vaccination history. Children under 13 months who are unvaccinated or partially vaccinated should complete the immunisation schedule.

These children should be investigated for immunological risk factors to seek a possible treatable condition predisposing them to infection. If they are found to fall into one of the risk groups in table 2, they should receive pneumococcal polysaccharide vaccine after the age of two years (and at least 2 months after the final dose of PCV).

All new cases of IPD in children eligible for routine or catch-up PCV will be followed up by the local NHS Board public health department in liaison with Health Protection Scotland. Those cases of IPD, who have been previously immunised with PCV, will be offered antibody testing against each of the 7 vaccine serotypes and advice on clinical and immunological investigation. A blood sample should be taken four weeks after infection to assess antibody response to disease and measure immunoglobulin levels. At this time, a booster dose of pneumococcal vaccine (irrespective of vaccination status of child) should be given. A second blood sample should be taken four weeks after vaccination to measure response to the booster dose.

## **7. Vaccination of children with unknown or incomplete status**

Where a child born in the UK presents with an inadequate or incomplete immunisation record, every effort should be made to clarify what vaccines they have had. A child who has not completed the routine programme for all vaccines should complete the course, including for pneumococcal vaccination. Children under 12 months of age require two doses of PCV, two months apart, followed by a dose at 13 months. Children aged between 12 and 24 months should be offered a single dose of PCV. Children aged over 24 months do not require vaccination.

Children coming to the UK may not have been offered pneumococcal vaccination previously. Where there is not reliable history of previous immunisation it should be assumed they are unimmunised and the UK recommendation should be followed.

## **8. Pneumococcal vaccination catch-up programme**

Details of the pneumococcal catch-up programme for all children under two years of age are listed in Annexes 2 and 3.

## **9. Pharmacy issues**

The following new vaccines will be offered as part of the routine programme. Full details on the products are available in the Summary of Product Characteristics (SPC).

### ***Pneumococcal Conjugate Vaccine (PCV)***

PCV, brand name Prevenar™ is manufactured by Wyeth Pharmaceuticals.

#### *Presentation*

Prevenar is presented as a suspension for injection in a pre-filled syringe supplied in a ten syringe pack without needles. The pack size (10 doses) is 144mm x 100mm x 63mm.

During storage a white deposit and clear supernatant can be seen. The vaccine should be shaken well to obtain a homogeneous white suspension and should not be used if it contains any particulate matter once shaken or shows any variation in appearance.

#### *Dosage*

A single dose of 0.5ml should be given at 2 months and 4 months followed by a third dose as a booster of 0.5ml at 13 months of age.

#### *Administration*

Vaccines are routinely given intramuscularly into the anterolateral thigh or the upper arm (infants over 1 year of age). This is to reduce the risk of localised reactions, which are more common when the vaccine is given subcutaneously. For individuals with a bleeding disorder, however, vaccines should be given by deep subcutaneous

injection to reduce the risk of bleeding. The vaccine can be given at the same time as other vaccines such as DTaP/IPV/Hib, MenC and MMR but in a different site.

It is recommended that infants under 1 year of age should be given vaccinations in the anterolateral aspect of the thigh. Where two injections are given in the same thigh, they should be separated by at least 2.5cm and a note be made of which vaccine is given in which site. This should be recorded in the Personal Child Health Record (PCHR – red book) and the child's GP record.

The vaccine must not be mixed with other concurrently administered vaccines.

### ***Hib-MenC Vaccine***

Hib-MenC, brand name Menitorix™ is manufactured by GlaxoSmithKline.

#### *Presentation*

Menitorix is presented as a one-dose pack containing a vial of white powder and a 0.5ml pre-filled syringe containing a clear colourless solvent. It is supplied with two separate needles - a green needle (21g x 38 mm) for reconstitution and a blue needle (23g x 25 mm) for administration. The pack size (one dose) is 55mm x 133mm x 35mm. Instructions for reconstitution of the vaccine are given at section 7 of the package leaflet.

#### *Dosage*

A single dose of 0.5ml is to be given as a booster at 12 months of age.

#### *Administration*

Vaccines are routinely given intramuscularly into the upper arm or anterolateral thigh. This is to reduce the risk of localised reactions, which are more common when the vaccine is given subcutaneously. For individuals with a bleeding disorder, however, vaccines should be given by deep subcutaneous injection to reduce the risk of bleeding.

#### ***Storage of vaccines***

Vaccines should be stored in the original packaging at +2°C to +8°C and protected from light. All vaccines are sensitive to some extent to heat and cold. Heat speeds up the decline in potency of most vaccines, thus reducing their shelf life. Effectiveness cannot be guaranteed for vaccines unless they have been stored at the correct temperature. Freezing may cause increased reactogenicity and loss of potency for some vaccines. It can also cause hairline cracks in the container, leading to contamination of the contents.

## **10. Reporting of adverse reactions**

Prevenar and Menitorix both carry a black triangle symbol (▼). This is a standard symbol added to the product information of a vaccine/medicine during the early

stages of marketing to encourage reporting of all suspected adverse reactions. If a doctor, nurse, pharmacist or parent suspects that any adverse reaction to one of these vaccines has occurred, they should report it to the Commission on Human Medicines (CHM) either the Yellow Card reporting form (e.g. in the BNF), the [www.yellowcard.gov.uk](http://www.yellowcard.gov.uk) website or by telephoning 0808 100 3352.

## **11. Vaccine supply**

Vaccine Holding Centres will be advised of their indicative allocation based on GRO and SIRS data within the next three weeks. An initial six weeks allocation will be made to Vaccine Holding Centres five weeks prior to the commencement date to enable them to supply GP Practices and clinics with a four week supply in time for the start of the campaign. Orders for vaccine, against the indicative allocation should be made in the usual way. Requests for amounts over and above the allocated amounts should be made in advance to Margaret Johnston at NSS National Procurement at email [Margaret.johnston2@nhs.net](mailto:Margaret.johnston2@nhs.net).

## **12. Vaccine Stock Management**

Effective management of vaccines throughout the supply chain is an essential part of reducing wastage and maximising efficiency of the programme. Even small reductions in vaccine wastage can have a major impact on vaccine supplies and their financing.

Practices need to review their holdings of MenC vaccine in particular as the new routine programme only requires two doses of MenC vaccine to be given.

Prevenar packaging is significantly larger than other vaccine currently provided. Please ensure sufficient fridge space is available for the new vaccines. Details of the pack size are given on page 7 of this letter.

## **13. Consumables**

Please note that needles will need to be ordered to administer Prevenar. The following product is recommended:

FTR163 blue needle 23g x 25 mm

This product may be ordered in the usual way. In order to manage the supplies of these consumables, please place regular orders to meet your needs rather than one very large order. Needles will not be supplied with the vaccine.

## **14. Vaccine call/recall**

The SIRS system will be amended in line with the new vaccine schedule.

General practices should advise SIRS of any children who have already received conjugate pneumococcal vaccine prior to the introduction of routine vaccination, i.e. those at increased risk of pneumococcal infection.

## **15. Patient Group Directions**

The requirement for Patient Group Directions (PGD) is described in HDL (2001)7, available from [http://www.show.scot.nhs.uk/sehd/mels/HDL2001\\_07.htm](http://www.show.scot.nhs.uk/sehd/mels/HDL2001_07.htm).

For those practices that choose to use PGDs, specimen PGDs for Prevenar and Menitorix are being developed and will be available at <http://www.show.scot.nhs.uk/sehd>. NHS Boards may choose to use these drafts as the basis of their PGDs and tailor them to reflect local needs.

## **16. Funding and Service Arrangements**

NHS Employers has reached agreement with the BMA General Practitioners Committee.

GPs will be remunerated £15.02 per child for the delivery of the pneumococcal vaccinations and the additional vaccination visit at 12 months to deliver the combined Hib and Men C vaccine. The Statement of Financial Entitlement will be amended and back dated to 4 September 2006.

The vaccines will be made available and distributed to the NHS through the Vaccine Holding Centres. The cost of the vaccine and administrative costs are expected to be met by NHS Boards.

## **17. Consent**

The changes to the vaccine programme will not affect the consent process: consent must be obtained before administration of all vaccines and is not brand specific.

Consent obtained before the occasion on which a child is brought for immunisation is only an agreement for the child to be included in the national childhood immunisation programme. It does not mean that consent is in place for each future immunisation. There is no legal requirement for consent to be in writing.

Health professionals involved in immunisation must ensure that:

- parents/carers have access to the new information;
- that there is sufficient opportunity for them to discuss any issues arising; and
- that they are properly informed of the benefits of the new vaccines, the possible side effects and how to treat them.

## **18. Information for parents and healthcare professionals**

To support the new changes to the childhood immunisation schedule NHS Health Scotland has produced a range of information resources. New leaflets, and factsheets for parents and healthcare professionals will be sent directly to GP practices, community pharmacists, health promotion units and NHS 24 call centres in August. These resources should be shared with all colleagues involved in giving or advising about immunisation, including health visitors, and practice nurses.

Further copies of these resources can be ordered from NHS Board Health Promotion Departments. In case of difficulty contact [marketing@health.scot.nhs.uk](mailto:marketing@health.scot.nhs.uk) .

Resources will also be available to view and download from the [www.healthscotland.com/immunisation](http://www.healthscotland.com/immunisation) website in August. The website will be updated to reflect the changes to the programme, and a new section for Hib/MenC immunisation is being created.



**TABLE 2 Pneumococcal Clinical Risk Groups for Children**

Note: All children, including those in clinical risk groups, should be offered PCV according to the new routine immunisation schedule. Children in the clinical risk groups listed below, aged 2 months to under 5 years of age should receive 7-valent pneumococcal conjugate vaccine (PCV), according to Annex 1, paragraph 5. This should be followed by a single dose of 23-valent pneumococcal polysaccharide vaccine when they are 2 years of age or over (and at least two months after the last dose of PCV). Children over 5 years of age should receive a single dose of pneumococcal polysaccharide vaccine.

<b>Clinical risk group</b>	<b>Examples (decision based on clinical judgement)</b>
<b>Asplenia or dysfunction of the spleen</b>	This includes conditions such as homozygous sickle cell disease and coeliac syndrome that may lead to splenic dysfunction.
<b>Chronic respiratory disease</b>	This includes chronic obstructive pulmonary disease (COPD), including chronic bronchitis and emphysema; and such conditions as bronchiectasis, cystic fibrosis, interstitial lung fibrosis, pneumoconiosis and bronchopulmonary dysplasia (BPD). Children with respiratory conditions caused by aspiration, or a neuromuscular disease (e.g. cerebral palsy) with a risk of aspiration. Asthma is not an indication, unless continuous or frequently repeated use of systemic steroids (as defined in Immunosuppression below) is needed.
<b>Chronic heart disease</b>	This includes those requiring regular medication and/or follow-up for ischaemic heart disease, congenital heart disease, hypertension with cardiac complications, and chronic heart failure.
<b>Chronic renal disease</b>	This includes nephrotic syndrome, chronic renal failure, renal transplantation.
<b>Chronic liver disease</b>	This includes cirrhosis, biliary atresia, chronic hepatitis
<b>Diabetes (requiring insulin or oral hypoglycaemic drugs)</b>	This includes type I diabetes requiring insulin or type 2 diabetes requiring oral hypoglycaemic drugs. It does not include diabetes that is diet controlled.
<b>Immunosuppression</b>	Due to disease or treatment, including asplenia or splenic dysfunction and HIV infection at all stages. Patients undergoing chemotherapy leading to immunosuppression. Individuals treated with or likely to be treated with systemic steroids for more than a month at a dose equivalent to prednisolone 20mg or more per day (any age), or for children under 20kg, a dose of $\geq 1\text{mg/kg/day}$ . <i>Some immunocompromised patients may have a suboptimal immunological response to the vaccine.</i>
<b>Individuals with cochlear implants</b>	<i>It is important that immunisation does not delay the cochlear implantation.</i> Where possible, pneumococcal vaccination should be completed at least 2 weeks prior to surgery to allow a protective immune response to develop. In some cases it will not be possible to complete the course prior to surgery. In this instance, the course should be started at any time prior to or following surgery and completed according to the immunisation schedule.
<b>Individuals with cerebrospinal fluid leaks</b>	This includes leakage of cerebrospinal fluid such as following trauma or major skull surgery.

## **Pneumococcal Vaccination Catch-Up Programme**

### **1. Timing of Pneumococcal Catch-Up Campaign**

The pneumococcal catch-up campaign will start on 4 September 2006. Our aim is to ensure that the target cohorts are offered vaccination appropriate for their age within 6 months of the start of the programme.

### **2. The Cohort**

Children who will be over 2 months of age and under 2 years of age at the time of introduction will need to be invited to receive pneumococcal vaccine.

Children aged 2 months or under at the time of introduction will be offered pneumococcal vaccine as part of the new routine immunisation programme (see Annex 1). Children over 2 years of age will not be part of the catch-up programme. The risk for children over 2 years of age becoming ill with pneumococcal infection is considerably less than in younger age groups. It is likely that pneumococcal infections in all age groups will fall as a result of introduction of the programme in the under two's.

### **3. The immunisations to be offered**

The recommended schedule for implementing the programme is summarised in Annex 3. The child's date of birth runs down the left-hand side of the table, and the month in which the vaccine is recommended to be given runs along the top of the table.

In summary:

Children born between 5 September 2004 and 3 August 2005 (i.e. aged over 13 months of age and under 2 years at the start of the programme) should be offered one dose of PCV.

Children born between 4 August 2005 and 3 February 2006 (i.e. aged 8 months to 13 months of age at the start of the programme) should be offered one dose of PCV at their routine 13 month visit.

Children born between 4 February 2006 and 3 July 2006 (i.e. aged over two months and under 8 months of age at the start of the programme) should be offered two doses of PCV separated by a period of two months. These children should also be offered a further dose at 13 months of age.

The following scenarios help to illustrate the use of the table:

- a) A baby born on 21 June 2006 should be offered PCV at the routine 4 month visit in October, a second dose at an additional 6 month visit in December, and then a booster dose at the scheduled 13 month visit.

- b) A child born 6 November 2005 should be offered PCV at the scheduled 13 month visit in December.
- c) A child born on 2 April 2005 should be offered one dose of PCV in November.
- d) A child born on 4 September 2004 is not eligible for the vaccine as they are over two years of age when the programme starts. Pneumococcal infections occur less frequently in children aged 2 years and over, and it is likely that pneumococcal infections in all age groups will fall as a result of introduction of the programme in the under two's.
- e) A baby born on 17 July 2006 will not be part of the catch-up programme. This baby will receive pneumococcal vaccination as part of the routine programme.

#### **4. Reporting of adverse reactions**

See page 8.

#### **5. Vaccine supply**

Vaccine Holding Centres will be advised of their indicative allocation based on GRO and SIRS data within the next three weeks. An initial six weeks allocation will be made to Vaccine Holding Centres five weeks prior to the commencement date to enable them to supply GP Practices and clinics with a four week supply in time for the start of the campaign. Orders for vaccine, against the indicative allocation should be made in the usual way. Requests for amounts over and above the allocated amounts should be made in advance to Margaret Johnston at NSS National Procurement at email [Margaret.johnston2@nhs.net](mailto:Margaret.johnston2@nhs.net)

#### **6. Vaccine stock management**

Managing supplies of vaccine during the pneumococcal catch-up programme presents challenges in vaccine management with which health professionals are familiar. All staff ordering vaccines need to ensure that vaccine wastage is reduced as far as possible by ensuring fridge space is available before ordering and storing the vaccine correctly. Practices who find that they have excess pneumococcal vaccine remaining at the end of the catch-up programme should use it in the routine programme. Vaccine wastage for this catch-up programme should be negligible.

#### **7. Consumables**

Please note that needles will need to be ordered to administer Prevenar.

FTR163 blue needle 23g x 25 mm

In order to manage the supplies of these consumables, please place regular orders to meet your needs rather than one very large order. Needles and syringes will not be supplied with the vaccine.

## **8. Vaccine call/recall**

The SIRS system will be amended in line with the new vaccine schedule.

General practices should advise SIRS of any children who have already received conjugate pneumococcal vaccine outwith the previous routine schedule, i.e. those at increased risk of pneumococcal infection.

General practices will need to provide sufficient additional vaccine appointments or catch-up clinics.

A draft letter is attached at Annex 4 for practices that send out their own appointments.

## **9. Patient Group Directions**

The requirement for Patient Group Directions (PGD) is described in HDL (2001)7, available from [http://www.show.scot.nhs.uk/sehd/mels/HDL2001\\_07.htm](http://www.show.scot.nhs.uk/sehd/mels/HDL2001_07.htm).

For those practices that choose to use PGDs, specimen PGDs for Prevenar and Menitorix are being developed and will be available at <http://www.show.scot.nhs.uk/sehd>. NHS Boards may choose to use these drafts as the basis of their PGDs and tailor them to reflect local needs.

## **10. Funding and service arrangements**

NHS Employers has reached agreement with the BMA General Practitioners Committee.

GPs will be remunerated £7.51 as an item of service payment for each child vaccinated. The Statement of Financial Entitlement will be amended and back dated to 4 September 2006.

The vaccines will be made available and distributed to the NHS through the Vaccine Holding Centres. The cost of the vaccine and administrative costs are expected to be met by NHS Boards.

## **11. Consent**

The introduction of the pneumococcal catch-up programme will not affect the consent process: consent must be obtained before administration of all vaccines and is not vaccine-product specific.

Consent obtained before the occasion on which a child is brought for immunisation is only an agreement for the child to be included in the national childhood immunisation programme. It does not mean that consent is in place for each future immunisation. There is no legal requirement for consent to be in writing.

Health professionals involved in immunisation must ensure that:

- parents/carers have access to the new information;
- that there is sufficient opportunity for them to discuss any issues arising, and
- that they are properly informed of the benefits of the new vaccines, the possible side effects, and how to treat them.

## **12. Information for parents and healthcare professionals**

To support the new changes to the childhood immunisation schedule NHS Health Scotland has produced a range of information resources. New leaflets, and factsheets for parents and healthcare professionals will be sent directly to GP practices, community pharmacists, health promotion units and NHS 24 call centres in August. These resources should be shared with all colleagues involved in giving or advising about immunisation, including health visitors, and practice nurses.

Further copies of these resources can be ordered from NHS Board Health Promotion Departments. In case of difficulty contact [marketing@health.scot.nhs.uk](mailto:marketing@health.scot.nhs.uk) .

Resources will also be available to view and download from the [www.healthscotland.com/immunisation](http://www.healthscotland.com/immunisation) website in August. The website will be updated to reflect the changes to the programme, and a new section for Hib/MenC immunisation is being created.

## Pneumococcal Vaccination Catch-Up Table

Recommended schedule for catch-up vaccination from 4 September 2006							
Child's date of birth	4 Sept to 3 Oct	4 Oct to 3 Nov	4 Nov to 3 Dec	4 Dec to 3 Jan	4 Jan to 3 Feb	4 Feb to 3 Mar	Child's age at vaccination (months)
5/9/04 to 3/11/04	√						23
4/11/04 to 3/12/04	√						22
4/12/04 to 3/1/05		√					22
4/1/05 to 3/2/05		√					21
4/2/05 to 3/3/05			√				21
4/3/05 to 3/4/05			√				20
4/4/05 to 3/5/05				√			20
4/5/05 to 3/6/05				√			19
4/6/05 to 3/7/05					√		19
4/7/05 to 3/8/05					√		18
4/8/05 to 3/9/05	√						13
4/9/05 to 3/10/05		√					13
4/10/05 to 3/11/05			√				13
4/11/05 to 3/12/05				√			13
4/12/05 to 3/1/06					√		13
4/1/06 to 3/2/06						√	13
4/2/06 to 3/3/06*		√		√			8, 10
4/3/06 to 3/4/06*		√		√			7, 9
4/4/06 to 3/5/06*	√		√				5, 7
4/5/06 to 3/6/06*	√		√				4, 6
4/6/06 to 3/7/06*		√		√			4, 6

## Notes

 Indicates the month in which the child should be offered PCV

\*Children in this age group will receive a booster dose of PCV at 13 months of age and a dose of Hib/MenC at 12 months of age.

Please note that there are sufficient supplies of PCV vaccine for all children born between 5/9/04 and 3/8/05 to be offered PCV as soon as it is practically possible after the start of the programme. This will provide general practices with the flexibility to immunise eligible children over a shorter time period.

**Suggested template letter of appointment for those practices sending out their own invitations for the pneumococcal catch-up programme**

PRACTICE NAME  
ADDRESS

[Date]

[Recipient's Address]

Dear Parent

The Scottish Government Health Directorate has recommended that your child needs a catch-up dose of pneumococcal conjugate vaccine (PCV). This vaccine has recently been introduced to the routine childhood immunisation programme and includes a catch-up for all children under two years of age. We are writing to invite you to bring your child for this vaccination on:

[date and time]

[venue]

This vaccination is important for your child because of the risks of pneumococcal disease, which include meningitis and septicaemia (blood poisoning) in children under two years of age. For more information about this vaccination, please read the leaflet (enclosed). If you have any further questions, please get in touch with your health visitor, practice nurse or GP.

As a practice we recommend pneumococcal conjugate vaccine for your child and hope that you will be able to bring your child for this appointment. If the above time and date is not suitable for you, please contact the practice to arrange another appointment.

Yours sincerely

[Click here and type your name]

## ANNEX J

### VACCINATIONS AND IMMUNISATIONS TO BE PROVIDED UNDER ADDITIONAL SERVICES

#### Persons Not Travelling Abroad

Disease	Groups of persons affected
1. Diphtheria Tetanus Either separately or combined	a. Children aged 6 and over who have not had the basic course of immunisation
	b. Staff in hospital considered to be at risk of infection of diphtheria (see Note 1)
	c. Children aged 6 and over who have had the basic course of immunisation but not a reinforcing dose.
2. Tetanus	a. If not previously immunised - children at 15-19 years of age or on leaving school; persons after leaving school.
	b. If previously immunised - persons on leaving school or entering higher education or starting work; thereafter, persons who have not had a reinforcing dose in <ul style="list-style-type: none"> <li>i. the previous 5 years, and then</li> <li>ii. the previous 5-15 years</li> </ul>
3. Poliomyelitis	a. Persons aged 6 years and under age 40 and parents/guardians of children being given oral polio vaccine. Groups at special risk (see Note 2). (Basic course).
	b. If previously immunised but without receiving a reinforcing dose - persons aged 6 and over at school or on leaving school or entering higher education or starting work. Groups at special risk (see Note 2.)
4. Smallpox (see Notes 3 and 4)	Groups at special risk (see Note 3).
5. Measles, Mumps, Rubella (MMR combined vaccine) Single Rubella	Children from age 6 to 15 years who have not been previously immunised with MMR combined vaccine. Women of child-bearing age who are not pregnant and are sero-negative; and male staff working in ante-natal clinics who are sero-negative.
5a. Measles, Mumps, Rubella second dose	i. Children given the pre-school MMR second dose at the same time as the Diphtheria, Tetanus and Polio pre-school immunisation (within the normal time frame for pre-school boosters).



	<p>ii. Children given the pre-school MMR second dose separately from one or more of the other pre-school boosters, that is Diphtheria, Tetanus and Polio, within the normal time frame for the pre-school boosters. (This is required only in cases where, in the judgement of the health professional giving the immunisations, it has not been possible to give all the pre-school boosters at the arranged initial appointment).</p> <p>iii. Children born after 1 January 1990 who are too old to be called for pre-school boosters after 1 October 1996, but are too young to have been in the 1994/95 MR campaign.</p>
6. Measles(single Antigen vaccine) (see Note 7)	Children from age 6 to 15 years who have not been immunised against measles and who have not had measles.
7. Rubella	Girls between their 10th and 14th birthdays who have not previously been immunised with MMR combined vaccine. Women of child-bearing age who are not pregnant and are sero-negative; and male staff working in ante-natal clinics who are sero-negative.
8. Anthrax	Groups at special risk (see Note 5).
9. Typhoid and Paratyphoid Either vaccine or typhoid combined	Staff in hospitals considered to be at risk of infection (see Note 1).
10. Rabies	Groups at special risk (see Note 6).
11. Infectious hepatitis	Persons in institutions who are exposed to a high risk of infection and for whom vaccination is recommended by the Community Medicine Specialist in Communicable Diseases.
11a. Haemophilus Influenzae b (Hib)	Children aged from 6 months to 3 years and 364 days on 1 April 2003, and all children who reach the age of 6 months between 1 April 2003 until 2 October 2003. (See Notes 8).
12. Vaccination in pursuance of public health policy (as in items 1-4 and 8-11) given as part of an emergency programme under the direction of the appropriate Board during a local outbreak of disease where the person vaccinated is a member of a group for which vaccination is recommended by the Community Medicine Specialist in Communicable Diseases, including a close contact of a person diagnosed by the general practitioner for whom vaccination is subsequently approved by the Community Medicine Specialist in Communicable Diseases.	
<b>Disease</b>	<b>Groups of persons affected</b>
12a. Group C Meningococcal	i. Children aged under 5 months will receive 3 doses (conjugate meningococcal C vaccine)
	ii. Children aged 5 months and to 11 months will receive 2 doses (conjugate meningococcal C vaccine)

	iii. Persons aged 12 months and up to and including age 24 years not previously immunised with conjugate meningococcal C vaccine will receive one dose (conjugate meningococcal C vaccine)
<b>12b. These payments reimburse GPs for immunising only those children and young people prioritised in the meningococcal C immunisation programme from Autumn 1999.</b>	
<b>Disease</b>	<b>Groups of persons affected</b>
12c. Pneumococcal Disease	Adults who are, or will reach, age 65 and over by 31 March 2004. Thereafter patients will be eligible on reaching 65.
<b>Persons Travelling Abroad</b>	
13. The following types of vaccinations are to be given to groups of persons leaving the United Kingdom for travel abroad, as defined below. Vaccination requirements of countries may vary and it is for the intending traveller to obtain authoritative information of the vaccination requirements of the country to be visited from the embassy/mission of that country.	
<b>Disease</b>	<b>Groups of persons affected</b>
14. Smallpox (see Note 4)	a. All persons travelling to Africa, Asia and America (including Canada and USA only when vaccination is a requirement of entry to those countries).
	b. All persons travelling to an infected area.
	c. All persons travelling to a country which requires visitors to have an International Certificate of Vaccination against Smallpox.
15. Typhoid and Paratyphoid Either typhoid vaccine or combined	a. All persons travelling outside the UK except to Canada, USA, Australia, New Zealand and northern Europe. ("Northern Europe" includes Belgium, Denmark, Iceland, the Netherlands, Norway and Sweden). b. All persons travelling to an infected area. c. All persons travelling to countries where it is a condition of entry that visitors should have been immunised.
16. Cholera	a. All persons travelling to Africa and Asia. b. All persons travelling to an infected area. c. All persons travelling to countries where it is a condition of entry that visitors should have been immunised.
17. Poliomyelitis	a. All persons travelling to countries outside Europe except Canada, USA, Australia, and New Zealand (Europe includes Cyprus and Turkey). b. All persons travelling to an infected area.

	c. All persons travelling to countries where it is a condition of entry that visitors should have been immunised.
18. Infectious hepatitis	Persons (particularly those) going to reside for 3 months or longer or who, if infected, might be less resistant because of pre-existing disease travelling outside Northern Europe, Australia or New Zealand to areas eg of poor sanitation, where the degree of exposure to infections is likely to be high.
<b>Note 1</b>	
Groups at special risk are hospital doctors and nurses and other staff likely to come into contact with cases of diphtheria, typhoid and paratyphoid, as the case may be, and laboratory staff likely to handle material contaminated with the organisms of these diseases.	
<b>Note 2</b>	
Groups at special risk and eligible for vaccination against poliomyelitis regardless of age are: General practitioners. General practitioners' practice staff in contact with patients. Ambulance staff. Medical students. Practising dental surgeons and others in contact with dental patients. Practising nurses in hospitals and elsewhere. Other hospital staff in contact with patients. Public health staff who may come into contact with poliomyelitis cases. The families of the above groups. Laboratory staff likely to handle material contaminated with poliomyelitis virus.	
<b>Note 3</b>	
Groups at special risk and eligible for vaccination and regular re-vaccination against smallpox regardless of age are:	
i. Regular re-vaccination at not less than yearly intervals: Doctors, nurses and others liable to serve on the staff of smallpox hospitals, any persons likely to have to deal at short notice with smallpox cases and laboratory staff likely to handle material contaminated with smallpox virus.	
ii. Regular re-vaccination at not less than 3-yearly intervals: Other health services staff who come into contact with patients.	
<b>Note 4</b>	
A vaccination or re-vaccination against smallpox is considered to be successful if a "major reaction" (as defined in paragraph 27 of the Memorandum on Vaccination against Smallpox, 1974) has occurred.	
<b>Note 5</b>	
The workers exposed to special risks of contracting anthrax are mainly those working in establishments such as tanneries, glue, gelatine, soap and bonemeal factories and woollen mills and regularly handling any of the raw materials shown below:	

Goat hair, including mohair and cashmere (unless previously disinfected by an approved factory in Great Britain).

East Indian wool, ie wool exported from India, Pakistan and Bangladesh.

Persian wool, ie wool exported from Persian Gulf ports, including wool from Iran, Iraq, Saudi-Arabia, Kuwait, etc.

Egyptian wool.

Chinese and Mongolian wool, ie wool exported from the People's Republic of China and the Mongolian People's Republic.

Alpaca.

Camel hair.

Tail or mane horsehair (raw or dressed) from the People's Republic of China, Taiwan, the Mongolian People's Republic or the Union of Soviet Socialist Republics.

Dry and dry-salted hides and skins imported from Africa, Asia and Central and South America.

Trimmings from dry and dry-salted raw hides, imported from Africa, Asia, and Central and South America.

Bones and bonemeal, hoof and horn meal imported from India, Pakistan and Bangladesh.

#### **Note 6**

Groups at special risk and eligible for vaccination against rabies regardless of age are:

- a. at kennels and catteries approved by the Ministry of Agriculture, Fisheries and Food for the quarantine of imported dogs, cats, etc;
- b. at quarantine premises in zoological establishments;
- c. by carrying agents authorised to carry imported dogs, cats, etc;
- d. at approved research and acclimatisation centres where primates and other imported mammals are housed;
- e. in laboratories handling rabies virus;
- f. at seaports and airports where they are likely to come into contact with imported animals or animals on ships or aircraft, eg Customs and Excise and police officers;
- g. as veterinary and technical staff of MAFF;
- h. as inspectors appointed by local authorities under the Diseases of Animal Act or employed otherwise who, by reason of their employment, encounter enhanced risk;
- i. those who regularly handle bats, including on a voluntary basis

and, where an area is declared to be rabies-infected by the Department of Agriculture, Fisheries and Food,

- j. Persons directly involved in control measures carried out under the direction of the Community Medicine Specialist in Communicable Diseases, together with veterinary surgeons engaged in private practice within the infected area and their ancillary staff.

Vaccine is issued, free of charge, by certain laboratories of the Public Health Service at the

request of the doctor undertaking the vaccination. The Community Medicine Specialist in Communicable Diseases can advise the practitioner on the recommended schedule of vaccination and the detailed arrangements for the supply of the vaccine.

**Note 7**

MMR combined vaccine should be given in preference to single-antigen measles vaccine and regardless of a history of mumps, measles or rubella infection.

**Note 8**

The haemophilus influenzae b (Hib) vaccine should be given in accordance with the aims of the catch-up campaign notified in the CMO letter dated 24 April 2003 (*SEHD/CMO(2003)6*) including supporting guidance, and with Chapter 8 of 'Immunisation against Infectious Disease', 1996 edition.