Quality And Outcomes Framework
Guidance for the GMS Contract Wales
2015/16

May 2015
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Section 1: Introduction

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

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

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

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

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

This document includes a copy of the summary of indicators for the 2015/16 QOF as set out in Annex D of the General Medical Services (GMS) Statement of Financial Entitlements Directions (SFE) and provides additional guidance on the indicators in Wales. It replaces all guidance issued in previous years. Annex D to the SFE forms part of the GMS contract for 2015/16.

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

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

These comments are fed in to a rolling programme of reviews and considered by the QOF Advisory Committee. The recommendations of the Committee will then be considered during negotiations between Welsh Government and the GPCW on potential changes to QOF. The online facility is available on the NICE website.

The focus for new indicators is provided by NICE Quality Standards. Interested individuals/organisations are encouraged to register with NICE as a stakeholder in the development of individual quality standards. Once registered, stakeholders are

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

### Principles

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

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

### 2015/16 GMS Contract Agreement

WG and GPCW agreed on changes to the GMS Contract for 2015/16 with the intention to reduce unnecessary bureaucracy and place greater reliance and trust on the professionalism of GPs to use their clinical judgement. The changes included the removal of 102 QOF points and the transfer of the associated funding into global sum equivalent. In placing greater reliance on the professionalism of GPs and the use of clinical judgement, it is expected that a more holistic patient centred approach will be taken to the management of some conditions and embedded good practice will continue without the need for a tick box target approach. WG and GPCW will work together to explore how activity on retired indicators is monitored to ensure there are no unintended consequences.

### General information on indicators

Indicators across all domains were renumbered from April 2013. Since April 2013 indicators have been prefixed by an abbreviation of the category to which they belong, for example coronary heart disease (CHD) indicator number one, became CHD001. The addition of zeros indicated the change from previous years numbering. From 2014/15 a consistent approach to numbering was adopted by Welsh Government, Scottish Government and the Northern Ireland Executive, the new

\(^2\) NICE website. Quality standards. [www.nice.org.uk/aboutnice/qof/qof.jsp](http://www.nice.org.uk/aboutnice/qof/qof.jsp)
approach means that a couple of indicators that were numbered 100W in 2013/14 were renumbered for 2014/15.

Indicators that have been developed through the NICE process\(^3\) are identified by the reference 'NICE [YEAR] menu ID: NMXX' for information. For 2015/16, a new indicator AF006 from the NICE indicator development process has been added into QOF this year.

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

- on the last day of the relevant financial year (31 March); or
- in the case where the contract terminates mid-year, on the last day on which the contract subsists. For example, for payments relating to the financial year 1 April 2015 to 31 March 2016, unless the contract terminates mid-year, achievement is measured on 31 March 2016. If the GMS contract ends on 30 June 2015, achievement is measured on 30 June 2015.

Indicators generally set out the target, intervention or measurement to be recorded within a specified time period to establish eligibility for achievement payments. Unless otherwise stated, time periods referred to mean the period which ends on the last day of the financial year to which the achievement relates. For example:

Indicator CAN003W – “The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the contractor receiving confirmation of the diagnosis, or where clinically appropriate within 3 months”, the phrase "within the preceding 15 months" means the period of 15 months which ends on 31 March in the financial year to which the achievement payments relate; This patient review can be undertaken via a telephone consultation but with an offer of a face to face appointment.

- Indicator HYP006 – “The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less”, the phrase “in the preceding 12 months” means the period of 12 months which ends on 31 March in the financial year to which the achievement payments relate.

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

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

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

\(^3\)NICE menu of indicators. [www.nice.org.uk/aboutnice/qof/indicators.jsp](http://www.nice.org.uk/aboutnice/qof/indicators.jsp)
Patients are considered to be 'currently treated' with a specified medicine if they have had a prescription for that medicine within the preceding six months ending on the last day of the financial year to which the achievement payments relate.

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

**Disease registers**

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

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

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

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

**Verification**

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

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

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

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

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

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

Data from GP clinical systems will be sent to CM Web for QOF achievement purposes.

The SFE states (paragraph D16): “The contractor must ensure that it is able to provide any information that the LHB may reasonably request of it to demonstrate that it is entitled to each achievement point to which it says it is entitled, and the contractor must make that information available to the LHB on request. In verifying that an indicator has been achieved and information correctly recorded.”

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

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

**Business rules**

In April 2010, the NHS Health and Social Care Information Centre (HSCIC) took over the development of the Business Rules from NHS Employers and NHS Connecting for Health (CfH). Different contractual arrangements for QOF will apply in each country for 2015/16, this will require different Business Rules to support QOF in Wales. The development of Business Rules to support QOF will be overseen by NHS Wales Informatics Service (NWIS) on behalf of Welsh Government. The clinical system suppliers to practices in Wales will work to the Business Rules developed to support QOF in Wales.

The Dataset and Business Rules that support the reporting requirements of the QOF are based entirely on Read codes (version 2 and Clinical Terms Version 3) and associated dates. Read codes are an NHS standard. Contractors using proprietary coding systems and/or local/practice specific codes will need to be aware that these codes will not be recognised within QOF reporting. Contractors utilising such systems may need to develop strategies to ensure that they are using appropriate Read codes in advance of producing their achievement report.
The Dataset and Business Rules and will be made available from the GMS Contract Wales website during 2015/16.

**Exception reporting**

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

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

“Exceptions” relate to registered patients who are on the relevant disease register or in the target population group and would ordinarily be included in the indicator denominator, but who are excepted by the contractor on the basis of one or more of the exception criteria. Patients are removed from the denominator and numerator for an indicator if they have been both excepted and they have not received the care specified in the indicator wording. If the patient has been excepted but subsequently the care has been carried out within the relevant time period the patient will be included in both the denominator and the numerator (e.g. achievement will always override an exception).

**Exception reporting criteria**

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

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

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

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

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

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

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4 GMS Contract Wales website. www.wales.nhs.uk/GMS
F. Where a patient has not tolerated medication.

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

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

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

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

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

Additional guidance on exception reporting can be found in section eight.
Section 2: Summary of all indicators

Section 2.1: Clinical domain

Section 2.1: applies to all contractors participating in QOF.

Atrial fibrillation (AF)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AF001. The contractor establishes and maintains a register of patients with atrial fibrillation</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Ongoing management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AF006 The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using CHA2DS2-VASc score risk stratification scoring system in the preceding 3 years (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more)</td>
<td>12</td>
<td>50-90%</td>
</tr>
<tr>
<td>AF007 In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anticoagulation drug therapy</td>
<td>12</td>
<td>40-70%</td>
</tr>
</tbody>
</table>

Secondary prevention of coronary heart disease (CHD)

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

Heart failure (HF)
<table>
<thead>
<tr>
<th>Records</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HF001. The contractor establishes and maintains a register of patients with heart failure</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HF005W. The percentage of patients with heart failure diagnosed within the preceding 15 months with a subsequent record of an offer of referral for an exercise-based rehabilitation programme within the preceding 15 months</td>
<td>5</td>
<td>40-90%</td>
</tr>
</tbody>
</table>

**Hypertension (HYP)**

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

**Stroke and transient ischaemic attack (STIA)**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STIA001. The contractor establishes and maintains a register of patients with stroke or TIA</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Indicator</td>
<td>Points</td>
<td>Achievement thresholds</td>
</tr>
<tr>
<td>----------------</td>
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<td>------------------------</td>
</tr>
<tr>
<td><strong>Records</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DM001. The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><em>NICE 2011 menu ID: NM41</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DM002. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less</td>
<td>8</td>
<td>51–91%</td>
</tr>
<tr>
<td><em>NICE 2010 menu ID: NM01</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DM003. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months) is 140/80 mmHg or less</td>
<td>10</td>
<td>40–72%</td>
</tr>
<tr>
<td><em>NICE 2010 menu ID: NM02</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DM007. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 15 months</td>
<td>17</td>
<td>40–72%</td>
</tr>
<tr>
<td><em>NICE 2010 menu ID: NM14</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DM012. The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 15 months</td>
<td>4</td>
<td>55–90%</td>
</tr>
<tr>
<td><em>NICE 2010 menu ID: NM13</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DM014. The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register</td>
<td>11</td>
<td>40–90%</td>
</tr>
<tr>
<td><em>NICE 2011 menu ID: NM27</em></td>
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</tbody>
</table>
### Asthma (AST)

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

### Chronic obstructive pulmonary disease (COPD)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
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</thead>
<tbody>
<tr>
<td><strong>Records</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPD001. The contractor establishes and maintains a register of patients with COPD</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Initial diagnosis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPD002. The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering on to the register</td>
<td>5</td>
<td>45–80%</td>
</tr>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPD003. The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 15 months</td>
<td>9</td>
<td>50–90%</td>
</tr>
</tbody>
</table>
COPD005. The percentage of patients with COPD and Medical Research Council dyspnoea grade ≥3 at any time in the preceding 15 months, with a record of oxygen saturation value within the preceding 15 months
*NICE 2012 menu ID: NM63*

<table>
<thead>
<tr>
<th>Points</th>
<th>Achievement thresholds</th>
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<tbody>
<tr>
<td>5</td>
<td>40-90%</td>
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</tbody>
</table>

COPD008W. The percentage of patients with COPD and Medical Research Council dyspnoea grade ≥3 at any time in the preceding 15 months, with a subsequent record of an offer of referral to a pulmonary rehabilitation programme within the preceding 15 months
*NICE 2012 menu ID: NM47*

<table>
<thead>
<tr>
<th>Points</th>
<th>Achievement thresholds</th>
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<tbody>
<tr>
<td>5</td>
<td>40-90%</td>
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</table>

### Dementia (DEM)

<table>
<thead>
<tr>
<th>Indicator</th>
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</thead>
<tbody>
<tr>
<td>Records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DEM001. The contractor establishes and maintains a register of patients diagnosed with dementia</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Ongoing management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DEM002. The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 15 months</td>
<td>28</td>
<td>35–70%</td>
</tr>
</tbody>
</table>

### Depression (DEP)

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

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

### Mental health (MH)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Records</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH001. The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH002. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 15 months, agreed between individuals, their family and/or carers as appropriate</td>
<td>6</td>
<td>40–90%</td>
</tr>
<tr>
<td>MH007. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months</td>
<td>4</td>
<td>50–90%</td>
</tr>
<tr>
<td>NICE 2010 menu ID: NM15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH009. The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months</td>
<td>1</td>
<td>50–90%</td>
</tr>
<tr>
<td>NICE 2010 menu ID: NM21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH010. The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months</td>
<td>2</td>
<td>50–90%</td>
</tr>
<tr>
<td>NICE 2010 menu ID: NM22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH011W. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure and BMI in the preceding 15 months and in addition for those aged 40 or over, a record of blood glucose or HbA1c in the preceding 15 months</td>
<td>12</td>
<td>45-85%</td>
</tr>
</tbody>
</table>
**Disease register for mental health**

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

**Remission from serious mental illness**

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

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

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

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

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

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

**Cancer (CAN)**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAN001</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

CAN001. The contractor establishes and maintains a register of all cancer patients defined as a ‘register of patients with a diagnosis of cancer excluding non-melanotic skin cancers diagnosed on or after 1 April 2003’
### Ongoing management

| CAN003W. The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the contractor receiving confirmation of the diagnosis, or where clinically appropriate within 3 months. This patient review can be undertaken via a telephone consultation but with an offer of a face to face appointment. |
|---|---|---|
| 6 | 50–90% |

### Epilepsy (EP)

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

### Learning disability (LD)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Records</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LD001. The contractor establishes and maintains a register of patients with learning disabilities</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
# Osteoporosis: secondary prevention of fragility fractures

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OST001. The contractor establishes and maintains a register of patients: 1. Aged 50 or over and who have not attained the age of 75 with a record of a fragility fracture on or after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and 2. Aged 75 or over with a record of a fragility fracture on or after 1 April 2012</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

**Disease register for osteoporosis**

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

# Rheumatoid arthritis (RA)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RA001. The contractor establishes and maintains a register of patients aged 16 or over with rheumatoid arthritis</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

**Ongoing management**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>RA002. The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 15 months</td>
<td>10</td>
<td>40–90%</td>
</tr>
</tbody>
</table>

# Palliative care (PC)

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

PC001. The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age

<p>| | |</p>
<table>
<thead>
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<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

Ongoing management

PC002W. The contractor has regular (at least 2 monthly) multi-disciplinary case review meetings where all patients on the palliative care register are discussed

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

Disease register for palliative care

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

Section 2.2.1: Public health domain

Section 2.2.1. applies to all contractors participating in QOF.

Cardiovascular disease – primary prevention (CVD-PP)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing management</td>
<td>10</td>
<td>40–90%</td>
</tr>
</tbody>
</table>

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

*NICE 2011 menu ID: NM26*

Disease register for CVD-PP

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

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

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

* NICE 2012 menu ID: NM61

## Obesity (OB)

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

## Smoking (SMOK)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMOK002. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 15 months</td>
<td>25</td>
<td>60–90%</td>
</tr>
</tbody>
</table>

* NICE 2011 menu ID: NM38

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMOK004. The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months</td>
<td>12</td>
<td>40–90%</td>
</tr>
</tbody>
</table>

* NICE 2011 menu ID: NM40

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMOK005. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 15 months</td>
<td>25</td>
<td>53–93%</td>
</tr>
</tbody>
</table>
Disease register for smoking

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

There is no APDF calculation for SMOK004.

Requirements for recording smoking status

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>CS001. The contractor has a protocol that is in line with national guidance agreed with the LHB for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate sample rates</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>CS002. The percentage of women aged 25 or over and who have not attained the age of 65 whose notes record that a cervical screening test has been performed in the preceding 5 years</td>
<td>11</td>
<td>45–80%</td>
</tr>
</tbody>
</table>

## Influenza (FLU)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>FLU001W. The percentage of the registered population aged 65 years of more who have had influenza immunisation in the preceding 1 August to 31 March</td>
<td>5</td>
<td>55-75%</td>
</tr>
<tr>
<td>FLU002W. The percentage of patients aged under 65 years included in (any of) the registers for CHD, COPD, Diabetes or Stroke who have had influenza immunisation in the preceding 1 August to 31 March</td>
<td>15</td>
<td>45-65%</td>
</tr>
</tbody>
</table>
Section 2.3 Medicines Management Domain

Section 2.3. applies to all contractors participating in QOF.

Medicines management

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>MED006W. The contractor meets the LHB prescribing advisor at twice per year, has agreed up to three actions related to prescribing and subsequently provided evidence of change</td>
<td>8</td>
</tr>
<tr>
<td>MED007W. A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed 4 or more repeat medicines Standard 80%</td>
<td>10</td>
</tr>
</tbody>
</table>
Section 3: Clinical domain

Clinical domain introduction

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

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

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

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

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

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

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

'xxx.1 Rationale'

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

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

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

'xxx.2 Reporting and verification'

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

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

## Indicator

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AF001. The contractor establishes and maintains a register of patients with atrial fibrillation</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Ongoing management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AF006 The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using CHA2DS2-VASc score risk stratification scoring system in the preceding 3 years (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more)</td>
<td>12</td>
<td>50-90%</td>
</tr>
<tr>
<td>AF007 In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anticoagulation drug therapy</td>
<td>12</td>
<td>40-70%</td>
</tr>
</tbody>
</table>

## AF – rationale for inclusion of indicator set

AF is common and significant cause or morbidity and mortality. The age-specific prevalence of AF is rising, presumably due to improved survival of patients with CHD (the commonest underlying cause of AF\(^6\)). One per cent of a typical practice population will be in AF; five per cent of patients aged 65 or over and nine percent of patients aged 75 or over. AF is associated with a five-fold increase in risk of stroke\(^7\).


## AF indicator 001

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

### AF 001.1 Rationale

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

### AF 001.2 Reporting and verification

See indicator wording for requirement criteria.

## AF Indicator 006

\(^6\) Psaty et al. Circulation 1997; 96: 2455-61

\(^7\) Wolf et al. Stroke 1991; 22: 983-88
The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using CHA2DS2-VASc score risk stratification scoring system in the preceding 3 years (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more).

AF 006.1 Rationale

The NICE guideline on atrial fibrillation 13 recommends that people with symptomatic or asymptomatic paroxysmal, persistent or permanent AF, atrial flutter and/or a continuing risk of arrhythmia recurrence after cardioversion back to sinus rhythm should have an assessment of their stroke risk using the CHA2DS2-VASc risk assessment tool.

The scoring system recommended is CHA2DS2-VASc, which is validated and gives a score that allows a better stratification of low-risk patients than the CHADS2 score 14. There is a clinical benefit in using a stroke risk score to identify patients at risk. The review of cohort studies found that there may be a slight benefit of CHA2DS2-VASc over the other scores considered (CHADS2, ACCP and the ACC/AHA/ESC).

The CHA2DS2-VASc system further develops the CHADS2 which is based on the AF Investigators I Study (AFI1) and Stroke Prevention in AF I Study (SPAF1) risk criteria 15, 16.

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

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

AF 006.2 Reporting and verification

See indicator wording for requirement criteria.

AF Indicator 007

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

AF 007.1 Rationale

This indicator aims to support the identification of people with AF who are at increased risk of stroke so that they may be offered anti-coagulation drug therapy.
Around 800,000 people in England are known to be at risk of stroke from AF. Of these, half are taking anti-coagulants and a third are currently taking aspirin. However, two-thirds of people admitted to a hospital with a stroke caused by AF are not taking recommended anti-coagulants. NICE estimates that with effective detection and protection with anti-coagulant drugs, 7,000 strokes and 2,000 premature deaths could be avoided each year 17.

Practices should not offer aspirin monotherapy solely for stroke prevention to people with AF. Evidence shows that aspirin is not as effective as anti-coagulants at preventing stroke in people with AF who are at increased risk of stroke and is also not as safe in terms of causing bleeding. Although the risks of anti-coagulation also increase with age, the evidence also shows that its benefits outweigh the risks in the vast majority of people with AF.

Stroke prevention therapy should not be offered to patients under 65 years with AF and no risk factors other than their sex (that is, very low risk of stroke equating to a CHA2DS2-VASc score of zero for men or one for women). Subsequent to this step, stroke prevention should be offered to those AF patients with one or more stroke risk factors.

Anti-coagulation should be offered to those patients with one or more stroke risk factors. A CHA2DS2-VASc score of one in women (women under age 65 with no other risk factors) should be regarded as low risk and should not receive anti-coagulation. Men with a CHA2DS2-VASc score of one should be regarded as at intermediate risk and a group in whom anti-coagulation should be considered.

All patients with AF and a CHA2DS2-VASc score of two or above should be offered anti-coagulation therapy taking their bleeding risk into account. Anti-platelet therapy has limited benefits for patients in preventing strokes and aspirin should not be offered to patients at increased risk of stroke. Offer anti-coagulation to people with a CHA2DS2-VASc score of two or above, taking bleeding risk into account. Anti-coagulation may be with apixaban, dabigatran etexilate, rivaroxaban or a vitamin K antagonist.

Anti-coagulation would not necessarily be indicated if the episode of AF was an isolated event that was not expected to re-occur (for example, one-off AF with a self-limiting cause).

When developing the guideline, NICE considered antiplatelet therapy to have limited benefits for AF patients in preventing strokes and made a strong recommendation that aspirin should not be offered to patients at increased risk of stroke. Therefore, the AF guideline highlights the importance of offering people with AF a personalised package of care which should cover stroke awareness and measures to prevent stroke.

NICE has produced a patient decision aid18 to support this guideline

**AF007.2 Reporting and Verification**

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

Secondary prevention of coronary heart disease (CHD)

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

CHD – rationale for inclusion of indicator set

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

CHD indicator 001

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

CHD 001.1 Rationale

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

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

CHD 001.2 Reporting and verification
See indicator wording for requirement criteria.
Heart failure (HF)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HF001. The contractor establishes and maintains a register of patients with heart failure</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>HF005W. The percentage of patients with heart failure diagnosed within the preceding 15 months with a subsequent record of an offer of referral for an exercise-based rehabilitation programme within the preceding 15 months</td>
<td>5</td>
<td>40-90%</td>
</tr>
</tbody>
</table>

NICE 2012 menu ID: NM48

HF – rationale for inclusion of indicator set

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

HF indicator 001

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

HF 001.1 Rationale
All patients with a diagnosis of HF, are included on the register.

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

HF indicator 005W (NICE 2012 menu ID: NM48)

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

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

GPs are advised to ensure that patients are stable and do not have conditions or devices that would preclude an exercise-based rehabilitation programme. These conditions and devices include uncontrolled ventricular response to AF and
uncontrolled hypertension high-energy pacing devices set to be activated at rates likely to be achieved during exercise.

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

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

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

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

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

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

HYP – rationale for inclusion of indicator set

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

HYP indicator 001

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

HYP 001.1 Rationale
A number of patients may be wrongly coded in this group, for example patients who have had one-off high blood pressure readings or women who have been hypertensive in pregnancy.

The NICE clinical guideline on hypertension\(^8\) uses the following definitions:

**Stage 1 hypertension**
Clinic blood pressure is 140/90 mmHg or higher and subsequent ambulatory blood pressure monitoring (ABPM) daytime average or home blood pressure monitoring (HBPM) average blood pressure is 135/85 mmHg or higher.

**Stage 2 hypertension**
Clinic blood pressure is 160/100 mmHg or higher and subsequent ABPM daytime average or HBPM average blood pressure is 150/95 mmHg or higher.

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

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

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

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

Further information

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

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

**HYP indicator 006**

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

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

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

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

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

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

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

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

Further information

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

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STIA001. The contractor establishes and maintains a register of patients with stroke or TIA</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

STIA – rationale for inclusion of indicator set

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

STIA indicator 001

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

STIA 001.1 Rationale

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

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

STIA 001.2 Reporting and verification

See indicator wording for requirement criteria.
## Diabetes mellitus (DM)

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

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

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

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

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

Further information


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

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

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

**DM 001.1 Rationale**

A greater understanding and knowledge of the complexities of diabetes has lead to increasing difficulty in accurately diagnosing or classifying the type of diabetes. In March 2011, a report by the Royal College of General Practitioners (RCGP) and NHS Diabetes was published which examined the issue of coding, classification and

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diagnosis of diabetes in primary care in England\textsuperscript{10}. The summary findings of the report included an algorithm to provide guidance to healthcare professionals on making a new diagnosis of diabetes\textsuperscript{11}. In line with this report, the diabetes register indicator includes all types of diabetes within the proposed algorithm. Gestational diabetes will continue to be excluded from this indicator set.

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

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

The World Health Organisation (WHO) 2006\textsuperscript{12} states that fasting plasma glucose $\geq 7.0$ mmol/l (126 mg/dl) or 2-h plasma glucose $\geq 11.1$ mmol/l (200 mg/dl) is used as criteria for diagnosing diabetes.

In 2011 an addendum to the 2006 WHO diagnostic criteria was published to allow the use of glycated haemoglobin (HbA1c) in diagnosing DM\textsuperscript{13}. The addendum does not invalidate the 2006 recommendations on the use of plasma glucose measurements to diagnose diabetes. The WHO recommend that HbA1c can be used as a diagnostic test for diabetes, provided that stringent quality assurance tests are in place and assays are standardised to criteria aligned to the international reference values, and there are no conditions present that preclude its accurate measurement. An HbA1c of 48 mmol/mol (6.5 per cent)\textsuperscript{14} is recommended as the cut-off point for diagnosing diabetes. A value less than 48 mmol/mol (6.5 per cent) does not exclude diabetes diagnosed using glucose tests. The WHO expert group concluded that there is currently insufficient evidence to make any formal recommendation on the interpretation of HbA1c levels below 48 mmol/mol (6.5 per cent).

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

\begin{thebibliography}{9}
\bibitem{11} NHS Diabetes. \url{www.diabetes.nhs.uk}
\bibitem{12} WHO. Definition and diagnosis of DM and intermediate hyperglycaemia 2006. \url{www.who.int/diabetes/publications/Definition%20and%20diagnosis%20of%20DM.pdf}
\bibitem{14} HbA1c should now be reported to the International Federation of Clinical Chemistry (IFCC) units of mmol/mol rather than the Diabetes Control and Complications Trial (DCCT) percentage.
\end{thebibliography}
The WHO also recommends that the diagnosis of diabetes in an asymptomatic patient is not made on the basis of a single abnormal plasma glucose or HbA1c value. At least one additional HbA1c or plasma glucose test result with a value in the diabetic range is required, either fasting, from a random (casual) sample, or from an oral glucose tolerance test (OGTT).

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

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

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

**DM indicator 002 (NICE 2010 menu ID: NM01)**

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

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

DM003 sets a target of 140/80 mmHg as per the target recommended by NICE\textsuperscript{15} while the target of 150/90 mmHg has been set for those patients who cannot manage this, such as those with retinopathy, micro-albuminuria or cerebrovascular disease.

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

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

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

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

**DM 003.1 Rationale**

\textsuperscript{15} NICE clinical guideline CG87. Type 2 diabetes – newer agents (partial update of CG66) 2008.  
www.nice.org.uk/CG87
Blood pressure lowering in patients with diabetes reduces the risk of macrovascular and microvascular disease.

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

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

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

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

**DM 007.1 Rationale**

There is a near linear relationship between glycaemic control and death rate in patients with type 2 diabetes\(^\text{16}\). In the EPIC Norfolk population cohort, a one per cent higher HbA1c was independently associated with 28 per cent higher risk of death, an association that extended below the diagnostic cut off for diabetes. These results suggest that, as with blood pressure and cholesterol, over the longer term at least, the lower the HbA1c the better\(^\text{17}\).

However, the Action to Control Cardiovascular Risk in Diabetes (ACCORD) trial highlighted the risks of adopting an aggressive treatment strategy for patients at risk of CVD. In the trial’s intervention group, HbA1c fell from 8.1 per cent to 6.4 per cent, but this was associated with increased mortality\(^\text{18}\). However, a recent meta-analysis did not confirm such an increase in risk\(^\text{19}\) and reassuringly, the ADVANCE study\(^\text{20}\) and the Veteran Affairs Diabetes Trial\(^\text{21}\) found no increase in all-cause mortality in their intensive treatment groups. Also, long-term follow up of the UK Prospective Diabetes Study demonstrated a ‘legacy effect’ with fewer deaths after ten years in those initially managed intensively\(^\text{22}\).

A retrospective analysis of cohort data from the UK General Practice Research Database (GPRD) has reopened the debate about how low to aim\(^\text{23}\). The study found that, among people whose treatment had been intensified by the addition of


\(^{20}\) ADVANCE collaborative group. Intensive blood glucose control and vascular outcomes in patients with type 2 diabetes. NEJM 2008; 358: 2560-72


\(^{22}\) Holman RR, Paul SK, Bethel MA et al. 10-year follow-up of intensive glucose control in type 2 diabetes 2008. NEJM; 359: 1577-89

insulin or a sulphonylurea, there was no benefit in reducing HbA1c below 59 mmol/mol, although these differences were not statistically significant. The mortality rate was higher among those with the tightest control (this lowest decile of cohort had HbA1c below 6.7 per cent; median = 6.4 per cent). The reasons for these findings are unclear, but they raise further questions about the possibility of some groups of patients for whom a tight glycaemic target is inappropriate.

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

- Offer structured education to every patient and/or their carer at and around the time of diagnosis, with annual reinforcement and review. Inform patients and their carers that structured education is an integral part of diabetes care.
- Provide individualised and ongoing nutritional advice from a healthcare professional with specific expertise and competencies in nutrition.
- When setting a target HbA1c:
  1. involve the patient in decisions about their individual HbA1c target level, which may be above that of 48 mmol/mol set for people with type 2 diabetes in general
  2. encourage the patient to maintain their individual target unless the resulting side effects (including hypoglycaemia) or their efforts to achieve this impair their quality of life
  3. offer therapy (lifestyle and medication) to help achieve and maintain the HbA1c target level
  4. inform a patient with higher HbA1c that reduction in HbA1c towards the agreed target is advantageous to future health
  5. avoid pursuing highly intensive management to levels of less than 48 mmol/mol.

The NICE and SIGN clinical guidelines are consistent\textsuperscript{24}.

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

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

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

<table>
<thead>
<tr>
<th>DCCT values for HbA1c (%)</th>
<th>IFCC values for HbA1c (mmol/mol)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.0</td>
<td>20</td>
</tr>
<tr>
<td>5.0</td>
<td>31</td>
</tr>
<tr>
<td>6.0</td>
<td>42</td>
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<td>6.5</td>
<td>48</td>
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<td>7.0</td>
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<tr>
<td>11.0</td>
<td>97</td>
</tr>
<tr>
<td>12.0</td>
<td>108</td>
</tr>
</tbody>
</table>

**DM 007.2 Reporting and verification**

See indicator wording for requirement criteria.

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

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

**DM 012.1 Rationale**

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

The foot inspection and assessment includes:
• identifying the presence of sensory neuropathy (loss of ability to feel a monofilament, vibration or sharp touch) and/or the abnormal build-up of callus

• identifying when the arterial supply to the foot is reduced (absent foot pulses, signs of tissue ischaemia or symptoms of intermittent claudication)

• identifying deformities or problems of the foot (including bony deformities, dry skin or fungal infection), which may put it at risk

• identifying other factors that may put the foot at risk (which may include reduced capacity for self-care, impaired renal function, poor glycaemic control, cardiovascular and cerebrovascular disease, or previous amputation).

The NICE clinical guideline on type 2 diabetes\textsuperscript{25} advises that foot risk is classified as:

• at low current risk: normal sensation, palpable pulses

• at increased risk: neuropathy or absent pulses or other risk factor

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

• ulcerated foot.

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

• discuss with the patient their individual level of risk and agree plans for future surveillance

• initiate appropriate referrals for expert review of those with increased risk

• give advice on action to be taken in the event of a new ulcer/lesion arising

• give advice on the use of footwear which will reduce the risk of a new ulcer/lesion

• give advice on other aspects of foot care which will reduce the risk of a new ulcer/lesion.

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

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

**DM indicator 014 (NICE 2011 menu ID: NM27)**

\textsuperscript{25} NICE clinical guideline CG10. Type 2 diabetes: prevention and management of foot problems 2004. [www.nice.org.uk/guidance/CG10](http://www.nice.org.uk/guidance/CG10)
The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register

**DM 014.1 Rationale**

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

The NICE technology appraisal on patient education models\(^{26}\) and the NICE clinical guideline on type 2 diabetes\(^{27}\) considered SE models for diabetes to be both clinically and cost-effective. There are a number of SE programmes available for diabetes. Some programmes will be more suitable for type 1 diabetes and others for type 2 diabetes.

The NICE quality standard for diabetes in adults\(^{28}\) is based on NICE clinical guidelines for diabetes\(^{29}\). The NICE quality statement on SE states that ‘People with diabetes and/or their carers receive a structured educational programme that fulfils the nationally agreed criteria from the time of diagnosis, with annual review and access to ongoing education’. The NICE quality standard states that a patient educational programme meets five key criteria laid down by the DH and the Diabetes UK Patient Education Working Group\(^{30}\):

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

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\(^{27}\) NICE clinical guideline CG87. Type 2 Diabetes: the management of type 2 diabetes 2010. [www.nice.org.uk/guidance/CG87](www.nice.org.uk/guidance/CG87)


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

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

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

The outcomes from the programme should be regularly audited.

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

A NICE commissioning guide on patient education programmes for people with type 2 diabetes\(^\text{\textsuperscript{31}}\) gives further information on providing services.

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

**DM 014.2 Reporting and verification**

See indicator wording for requirement criteria.

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### Asthma (AST)

#### Indicator | Points | Achievement thresholds
--- | --- | ---
**Records**

AST001. The contractor establishes and maintains a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the preceding 12 months | 2 |  

**Ongoing management**

AST003. The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 15 months that includes an assessment of asthma control using the 3 RCP questions

*NICE 2011 menu ID: NM23* | 20 | 45–70%

AST004. The percentage of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, in whom there is a record of smoking status in the preceding 15 months | 6 | 50–80%

#### AST – rationale for inclusion of indicator set

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

### AST indicator 001

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

#### AST 001.1 Rationale

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

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

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

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

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

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

Further information

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

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

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

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

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

**AST 003.1 Rationale**

Structured care has been shown to produce benefits for patients with asthma. The reckoning of morbidity, PEF levels, inhaler technique and current treatment and the promotion of self-management skills are common themes of good structured care. The BTS/SIGN clinical guideline\(^ {32}\) proposes a structured system for recording inhaler technique, morbidity, PEF levels, current treatment and asthma action plans.

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

The QOF now explicitly requires that the following RCP questions\(^ {33}\) are used as an effective way of assessing symptoms:

In the last month:

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

The questions are to be asked at the same time and as part of the review. A response of ‘No’ to all questions is consistent with well-controlled asthma\(^ {34}\).

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

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

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\(^{33}\) RCP. Pearson MG, Bucknall CE, editors. Measuring clinical outcomes in asthma: patient focused approach.

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

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

During an asthma review the following takes place:

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

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

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

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

**AST indicator 004**

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

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

Studies of smoking related to asthma are surprisingly few in number. Starting smoking as a teenager increases the risk of persisting asthma. There are very few
studies that have considered the question of whether smoking affects asthma severity. One controlled cohort study suggested that exposure to passive smoke at home delayed the recovery from an acute attack. There is also epidemiological evidence that smoking is associated with poor asthma control\textsuperscript{35}.

It is recommended that smoking cessation be encouraged as it is good for general health and may decrease asthma severity\textsuperscript{36}.

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

\textsuperscript{36} Thomson et al. Euro Respiratory Journal 2004; 24: 822-833
Chronic obstructive pulmonary disease (COPD)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPD001. The contractor establishes and maintains a register of patients with COPD</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Initial diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPD002. The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering on to the register</td>
<td>5</td>
<td>45–80%</td>
</tr>
<tr>
<td>Ongoing management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPD003. The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 15 months</td>
<td>9</td>
<td>50–90%</td>
</tr>
<tr>
<td>COPD005. The percentage of patients with COPD and Medical Research Council dyspnoea grade ≥3 at any time in the preceding 15 months, with a record of oxygen saturation value within the preceding 15 months</td>
<td>5</td>
<td>40-90%</td>
</tr>
<tr>
<td>COPD008W. The percentage of patients with COPD and Medical Research Council dyspnoea grade ≥3 at any time in the preceding 15 months, with a subsequent record of an offer of referral to a pulmonary rehabilitation programme within the preceding 15 months</td>
<td>5</td>
<td>40-90%</td>
</tr>
</tbody>
</table>

COPD – rationale for inclusion of indicator set

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

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

**COPD indicator 001**

The contractor establishes and maintains a register of patients with COPD

**COPD 001.1 Rationale**

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

See COPD 002.1

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

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

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

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

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

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

COPD indicator 002

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

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

The NICE clinical guideline on COPD \(^{39}\) provides the following definition of COPD:


\(^{38}\) Global Initiative for Chronic Obstructive Lung Disease (GOLD). Global strategy for the diagnosis, management and prevention of COPD 2008.

airflow obstruction is defined as a reduced FEV\textsubscript{1}/FVC ratio (where FEV\textsubscript{1} is forced expired volume in one second and FVC is forced vital capacity), such that FEV\textsubscript{1}/FVC is < 0.7

if FEV\textsubscript{1} is greater than or equal to 80 per cent predicted normal a diagnosis of COPD would only be made in the presence of respiratory symptoms, for example breathlessness or cough.

The NICE clinical guideline requires post bronchodilator spirometry for diagnosis and gradation of severity of airways obstruction. Failure to use post bronchodilator readings has been shown to overestimate the prevalence of COPD by 25 per cent\textsuperscript{40}. Spirometry is to be performed after the administration of an adequate dose of an inhaled bronchodilator (e.g. 400 mcg salbutamol).

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

Routine reversibility testing is not recommended. However, where doubt exists as to whether the diagnosis is asthma or COPD, reversibility testing may add additional information to post bronchodilator readings alone and peak flow charts are useful. It is acknowledged that COPD and asthma can co-exist and that many patients with asthma who smoke will eventually develop irreversible airways obstruction. Where asthma is present, these patients would be managed as asthma patients as well as COPD patients. This will be evidenced by a greater than 400mls response to a reversibility test and a post bronchodilator FEV\textsubscript{1} of less than 80 per cent of predicted normal as well as an appropriate medical history.

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

The guideline on COPD recommends that all health professionals involved in the care of patients with COPD have access to spirometry and be competent in the interpretation of the results. Quality statement 1 (diagnosis) in the NICE quality standard for COPD in adults\textsuperscript{41}, states that patients with COPD have the diagnosis confirmed by post bronchodilator spirometry carried out on calibrated equipment by healthcare professionals competent in its performance and interpretation.

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

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

\textsuperscript{40} Johannessen et al. Thorax 2005; 60(10): 842-847
\textsuperscript{41} NICE quality standard on COPD 2011. http://www.nice.org.uk/guidance/qualitystandards/chronicobstructivepulmonarydisease/copdqualitystandard.jsp
COPD indicator 003

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

COPD 003.1 Rationale
COPD is increasingly recognised as a treatable disease with large improvements in symptoms, health status, exacerbation rates and even mortality if managed appropriately. Appropriate management is based on NICE clinical guideline CG101 and international GOLD guidelines in terms of both drug and non-drug therapy.

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

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

A tool such as the Clinical COPD Questionnaire\(^2\) could be used to assess current health status.

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

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

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

COPD indicator 005 (NICE 2012 menu ID: NM63)

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

COPD 005.1 Rationale

\(^2\) Clinical COPD Questionnaire. http://www.ccq.nl/
As COPD progresses, patients often become hypoxaemic. Many patients tolerate mild hypoxaemia well, but once the resting partial pressure of oxygen in arterial blood (PaO2) falls below 8 KPa patients begin to develop signs of right-sided HF (cor pulmonale), principally peripheral oedema. The prognosis is poor and if untreated the five year survival is less than 50 per cent.

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

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

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

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

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

COPD indicator 008W (NICE 2012 menu ID: NM47)

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

COPD 008W.1 Rationale
Pulmonary rehabilitation is defined as a multidisciplinary programme of care for patients with chronic respiratory impairment. It is individually tailored and designed to optimise each patient’s physical and social performance and independence. Its aim is to reduce disability and to improve quality of life.
NICE clinical guideline CG101 recommends that the programme is offered to all patients who consider themselves to be functionally disabled by their COPD (MRC grade greater than or equal to three). While most patients are likely to benefit, a pulmonary rehabilitation programme is not suitable for patients who are unable to walk, have unstable angina or who have recently had an MI.

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

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

See indicator wording for requirement criteria.

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

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

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DEM001. The contractor establishes and maintains a register of patients diagnosed with dementia</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Ongoing management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DEM002. The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 15 months</td>
<td>28</td>
<td>35–70%</td>
</tr>
</tbody>
</table>

DEM – rationale for inclusion of indicator set

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

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

DEM indicator 001

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

DEM 001.1 Rationale

There is little evidence to support screening for dementia and it is expected that the diagnosis will largely be recorded from correspondence when patients are referred to secondary care with suspected dementia or as an additional diagnosis when a patient is seen in secondary care. However it is also important to include patients where it is inappropriate or not possible to refer to a secondary care provider for a diagnosis and where the GP has made a diagnosis based on their clinical judgement and knowledge of the patient.
DEM 001.2 Reporting and verification
See indicator wording for requirement criteria.

DEM indicator 002
The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 15 months

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

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

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

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

Depression could also be considered as it is more common in patients with dementia than those without.\(^\text{43}\)

Patients and carers are to be given relevant information about the diagnosis and sources of help and support (bearing in mind issues of confidentiality). Evidence suggests that healthcare professionals can improve satisfaction for carers by acknowledging and dealing with their distress and providing more information on dementia.\(^\text{44}\) 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

\(^{44}\) Eccles et al. BMJ 1998; 317: 802-808
person with dementia and the effect this has on the caregiver. It is important to remember that male carers are less likely to complain spontaneously and that the impact of caring is dependent not on the severity of the cognitive impairment but on the presentation of the dementia, for example, on factors such as behaviour and affect. If the carer is not registered at the practice, but the GP is concerned about issues raised in the consultation, then with appropriate permissions they can contact the carer’s own GP for further support and treatment.

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

Further information


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

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

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

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

Depression is common and disabling.

In 2000, the estimated point prevalence for a depressive episode among people aged 16 or over and under the age of 74 in the UK was 2.6 per cent (males 2.3 per cent, females 2.8 per cent). If the broader and less specific category of ‘mixed depression and anxiety’ is included, these figures increase dramatically to 11.4 per cent (males 9.1 per cent, females 13.6 per cent). It contributes 12 per cent of the total burden of non-fatal global disease and by 2020, looks set to be second after CVD in terms of the world’s disabling diseases. Major depressive disorder is increasingly seen as chronic and relapsing, resulting in high levels of personal disability, lost quality of life for patients, their family and carers, multiple morbidity, suicide, higher levels of service use and many associated economic costs. In 2000, 109.7 million lost working days and 2615 deaths were attributable to depression. The total annual cost of adult depression in England has been estimated at over £9 billion, of which £370 million represents direct treatment costs.

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

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

**DEP 003W.1 Rationale**

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

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

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

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

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

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

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

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

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

**DEP 003W.2 Reporting and verification**
See indicator wording for requirement criteria.

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

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

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

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

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

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Mental health (MH)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Records</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH001. The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH002. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 15 months, agreed between individuals, their family and/or carers as appropriate</td>
<td>6</td>
<td>40–90%</td>
</tr>
<tr>
<td>MH007. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months</td>
<td>4</td>
<td>50–90%</td>
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<tr>
<td>NICE 2010 menu ID: NM15</td>
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<tr>
<td>MH009. The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months</td>
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<td>50–90%</td>
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<tr>
<td>NICE 2010 menu ID: NM21</td>
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<tr>
<td>MH010. The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months</td>
<td>2</td>
<td>50–90%</td>
</tr>
<tr>
<td>NICE 2010 menu ID: NM22</td>
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</tr>
<tr>
<td>MH011W. The percentage of patients with schizophrenia, Bipolar affective disorder and other psychoses who have a record of blood pressure and BMI in the preceding 15 months and in addition for those aged 40 or over, a record of blood glucose of HbA1c in the preceding 15 months</td>
<td>12</td>
<td>45-85%</td>
</tr>
</tbody>
</table>

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

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

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

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

**Mental health indicators MH007 and MH11W**

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

The components of an annual review have been separated out to create a series of indicators. The annual timeframe for these indicators is in line with the NICE clinical guideline on schizophrenia.\(^50\)

The NICE clinical guideline on bipolar disorder\(^51\) recommends that patients with bipolar affective disorder have an annual physical health review, normally in primary care, to ensure that the following are assessed each year:

- lipid levels, including cholesterol in all patients aged 40 or over even if there is no other indication of risk
- plasma glucose levels
- weight
- smoking status and alcohol use
- blood pressure.

In addition to lifestyle factors, such as smoking, poor diet and lack of exercise, antipsychotic drugs vary in their liability for metabolic side effects such as weight gain, lipid abnormalities and disturbance of glucose regulation. Specifically, they increase the risk of the metabolic syndrome, a recognised cluster of features

\(^{50}\) NICE clinical guideline CG82. Schizophrenia. Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care 2009. [www.nice.org.uk/guidance/CG82](http://www.nice.org.uk/guidance/CG82)

\(^{51}\) NICE clinical guideline CG38. Bipolar disorder. The management of bipolar disorder on adults, children and adolescents, in primary and secondary care 2006. [www.nice.org.uk/guidance/CG38](http://www.nice.org.uk/guidance/CG38)
(hypertension, central obesity, glucose intolerance or insulin resistance or dyslipidaemia) which is a predictor of type 2 diabetes and CHD.\(^{52}\)

**MH indicator 001**

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

**MH 001.1 Rationale**

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

**Remission from serious mental illness**

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

Making an accurate diagnosis of remission for a patient with a diagnosis of serious mental illness can be challenging and the evidence base to support when to use the ‘remission code’ is largely based on clinical judgement. A longitudinal international study of recovery from psychotic illnesses found that as many as 56 per cent of patients recovered from psychotic illnesses to some extent, although only 16 per cent recover if a more stringent concept of recovery\(^ {53}\) is used.

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

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

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

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

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

**MH 001.2 Reporting and verification**

See indicator wording for requirement criteria.

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

Verification – the LHB may require randomly selecting a number of patient records of patients in which a ‘remission code’ has been recorded and request evidence as to why it was appropriate for that patient to be considered ‘in remission’.

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

The LHB may require contractors to demonstrate that patients coded as being in remission have received no anti-psychotic medications, mental health in-patient admissions, or mental health secondary or community care for at least five years prior to the entry of the remission code in their record.

**MH indicator 002**

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

**MH 002.1 Rationale**

This indicator reflects good professional practice and is supported by NICE clinical guidelines\(^54\).

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

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

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\(^54\) NICE clinical guideline CG82. Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care 2009. [http://guidance.nice.org.uk/CB82/NICEGuidance/pdf/English](http://guidance.nice.org.uk/CB82/NICEGuidance/pdf/English)
When constructing the primary care record, research supports the inclusion of the following information:

1. Patient's current health status and social care needs including how needs are to be met, by whom, and the patient's expectations.

2. How socially supported the individual is: e.g. friendships/family contacts/voluntary sector organisation involvement. People with mental health problems have fewer social networks than average, with many of their contacts related to health services rather than sports, family, faith, employment, education or arts and culture. One survey found that 40 per cent of people with ongoing mental health problems had no social contacts outside mental health services.55

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

4. Occupational status. In England, only 24 per cent of people with mental health problems are currently in work, the lowest employment rate of any group of people (office of national statistics (ONS) Labour Force Survey, Autumn 2003). People with mental health problems also earn only two thirds of the national average hourly rate (ONS, 2002). Studies show a clear interest in work and employment activities among users of mental health services with up to 90 per cent wishing to go into or back to work.56

5. “Early warning signs” from the patient’s perspective that may indicate a possible relapse.57 Many patients may already be aware of their early warning signs (or relapse signature) but it is important for the primary care team to also be aware of noticeable changes in thoughts, perceptions, feelings and behaviours leading up to their most recent episode of illness as well as any events the patient thinks may have acted as triggers.

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

It is recommended that a care and treatment plan is accurate, easily understood, reviewed annually and discussed with the patient, their family and/or carers. If a patient is treated under the Mental Health Wales Measure byt secondary care services, then they have a documented care and treatment plan discussed with their care co-ordinator available. This is acceptable for the purposes of QOF.

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

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

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

MH indicator 007 (NICE 2010 menu ID: NM15)
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months

MH 007.1 Rationale
Substance misuse by people with schizophrenia is increasingly recognised as a major problem, both in terms of its prevalence and its clinical and social effects. The National Psychiatric Morbidity Survey in England found that 16 per cent of people with schizophrenia were drinking over the recommended limits of 21 units of alcohol for men and 14 units of alcohol for women a week. Bipolar affective disorder is also highly co-morbid with alcohol and other substance abuse.

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

MH indicator 009 (NICE 2010 menu ID: NM21)
The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months

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

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

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

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

MH indicator 010 (NICE 2010 menu ID: NM22)

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

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

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

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

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

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

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

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62 NPSA alert 0921. Safer lithium therapy 2009. [www.nrls.npsa.uk/alerts](http://www.nrls.npsa.uk/alerts)

MH 010.2 Reporting and verification
See indicator wording for requirement criteria.

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

MH indicator 011
The percentage of patients with schizophrenia, Bipolar affective disorder and other psychoses who have a record of blood pressure and BMI in the preceding 15 months and in addition for those aged 40 or over, a record of blood glucose of HbA1c in the preceding 15 months...

MH 011W.1 Rationale

Patients with schizophrenia have mortality between two and three times that of the general population and most excess deaths are from diseases that are the major causes of death in the general population. There is evidence to suggest that physical conditions such as cardiovascular disorders go unrecognised in psychiatric patients. Patients with psychosis may lead more sedentary lives, eat less fruit and vegetables, be much more likely to be obese and are more likely to smoke cigarettes. There is insufficient evidence to support the use of blood glucose testing in patients of all ages and therefore an age limit of 40 or over has been adopted for this part of the indicator.

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

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

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

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

**CAN indicator 001**

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

**CAN 001.1 Rationale**

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

**CAN 001.2 Reporting and verification**

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

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

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

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

A cancer review in primary care includes:

- The patient’s individual health and support needs, which will vary with, for example, the diagnosis, staging, age and pre-morbid health of the patient and their social support networks. In collaboration with the National Cancer Survivorship Initiative (NCSI)64, Macmillan primary care community has produced a template65 which recommends that this could cover a discussion of the diagnosis and recording of cancer therapy, an offer of relevant information, medication review, benefits counselling and recording of a carer’s details.

- The coordination of care between sectors.

Further information on survivorship and the potential role for primary care can be found on the NCSI website66.

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

CAN 003W.2 Reporting and verification
See indicator wording for requirement criteria.

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

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

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

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

**EP indicator 001**

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

**EP 001.1 Rationale**

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

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

**EP 001.2 Reporting and verification**

See indicator wording for requirement criteria.

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

**EP indicator 003W**

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

**EP 003W.1 Rationale**

It is estimated that in the UK 131,000 women with epilepsy are of child bearing age (12 or over and under the age of 50). Approximately 25 per cent of all patients with epilepsy are women of reproductive age and one in 200 women attending antenatal clinics are receiving antiepileptic drugs (AEDs)\(^{67}\). Around 2500 women with epilepsy will have a baby each year in the UK.

AEDs taken during pregnancy are associated with an increased risk of major congenital malformation (MCMs). Women in the general population have a one or two per cent chance of having a baby with an MCM. Women with epilepsy taking one AED have a chance of having a baby with an MCM of slightly over 3.5 per cent, while for women taking two or more AEDs the average chance increases to 6 per cent\(^{68}\). The risk of MCMs occurring can relate to having epilepsy and to taking AEDs while pregnant.

In a survey of women with epilepsy, only 28 per cent of participants aged 19 or over and under the age of 34 have received information about oral contraception and epilepsy medication\(^{69}\). 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.

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\(^{67}\) Royal Society of Medicine. Primary Care guidelines for the management of females with epilepsy 2004. [http://www.rsm.ac.uk/media/downloads/epiguide_pdf.pdf](http://www.rsm.ac.uk/media/downloads/epiguide_pdf.pdf)


\(^{69}\) Crawford P, Hudson S. Understanding the information needs of women with epilepsy at different life stages: results of the 'Ideal World' survey 2003. Seizure 12: 502-7
NICE clinical guideline CG137 on epilepsy made the following recommendation as a key priority for implementation:

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

SIGN clinical guideline 70 on epilepsy states:

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

Clinicians are advised to use their judgement as well as the evidence base presented in this guidance to ensure that appropriate advice is given and is tailored to the women's individual needs. Not all three pieces of advice (contraception, conception and pregnancy) need to be given at the same time, but may be given separately at any point over the 3 years period.

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

**EP 003W.2 Reporting and verification**
See indicator wording for requirement criteria.

The Business Rules require that contractors deliver all three pieces of advice as described in this indicator in order to meet the requirements for this indicator. However, the advice does not need to be given on the same day. Where one or more of these elements of advice are not clinically appropriate, for example if the patient is already pregnant, then normal exception reporting rules apply.

Verification - the LHB may require contractors to demonstrate how patients are given such advice e.g. provide examples of leaflets and any specific practice protocols. Evidence that the advice has been given in the context of a face-to-face consultation may be demonstrated by a print out of summary of appointment bookings.
Learning disabilities (LD)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LD001. The contractor establishes and maintains a register of patients with learning disabilities</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

LD – rationale for inclusion of indicator set

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

Further information


LD indicator 001

The contractor establishes and maintains a register of patients with learning disabilities
LD 001.1 Rationale
The idea of a learning disability register for adults in primary care has been widely recommended by professionals and charities alike\(^\text{70}\). The creation of a full register of patients with learning disabilities will provide primary care practitioners with the first important building block in providing better quality and more appropriate services for this patient population.

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

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

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

The definition does not include all those people who have a “learning difficulty”, e.g. specific difficulties with learning, such as dyslexia.

For many people, there is little difficulty in reaching a decision whether they have a learning disability or not. However, in those individuals where there is some doubt about the diagnosis and the level of learning disability, referral to a multi-disciplinary specialist learning disability team (where available) may be necessary to assess the degree of disability and diagnose any underlying condition. In some areas, Locality Community Learning Disability Teams, working along with LHBs, provide expertise and data about and for people with learning disabilities. Contractors may wish to liaise with Social Services Departments, Community Learning Disability Teams and Primary Healthcare Facilitators where available to assist in the construction of a primary care database\(^\text{71}\).

Further information


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

\(^{70}\) See Treat Me Right, Mencap 2004. [www.mencap.org.uk](http://www.mencap.org.uk)

Osteoporosis: secondary prevention of fragility fractures (OST)

**Indicator**  
**Points**  
**Achievement thresholds**  

<table>
<thead>
<tr>
<th>Records</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>OST001. The contractor establishes and maintains a register of patients:</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1. Aged 50 or over and who have not attained the age of 75 with a record of a fragility fracture on or after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan; and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Aged 75 or over with a record of a fragility fracture on or after 1 April 2012</td>
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</tbody>
</table>

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

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

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

**OST indicator 001 (NICE 2011 menu ID: NM29)**

The contractor establishes and maintains a register of patients:

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

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

**OST 001.1 Rationale**

Fragility fractures are fractures that result from low-level trauma, which means mechanical forces that would not ordinarily cause fracture. The WHO has described
this as a force equivalent to a fall from a standing height or less. Reduced bone density is a major risk factor for fragility fractures.\(^\text{72}\)

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

The NICE clinical guideline on osteoporosis fragility fractures\(^\text{73}\) recommends that a diagnosis of osteoporosis may be assumed in women and men aged 75 or over with a fragility fracture if the responsible clinician considers a DXA scan to be clinically inappropriate or unfeasible.\(^\text{74}\) The SIGN clinical guideline on the management of osteoporosis\(^\text{75}\) recommends that in frail elderly women (aged 80 or over) a DXA scan would be a prerequisite to establish that bone mass density (BMD) is sufficiently low before starting treatment with bone-sparing agents (bisphosphonates), unless the patient has suffered multiple vertebral fractures.

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

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

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

Hip fractures are associated with increased mortality; estimates of the relative mortality risk vary from two to greater than ten in the 12 months following hip.

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\(^{72}\) WHO. Guidelines for preclinical evaluation and clinical trials in osteoporosis 1998.

\(^{73}\) NICE clinical guideline CG146. Osteoporosis fragility fracture 2012. [http://www.nice.org.uk/CG146](http://www.nice.org.uk/CG146)


fracture. However, it is unclear to what extent this can be attributed to fracture alone, as opposed to pre-existing co-morbidity\textsuperscript{76}.

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

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

**OST 001.2 Reporting and verification**
The Business Rules for the two part register will look for the following criteria:

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

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

In patients aged 75 or over:

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

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

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

\textsuperscript{76} WHO. Guidelines for preclinical evaluation and clinical trials in osteoporosis 1998.
Rheumatoid arthritis (RA)

<table>
<thead>
<tr>
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<tr>
<td>Records</td>
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<td></td>
</tr>
<tr>
<td>RA001. The contractor establishes and maintains a register of patients aged 16 or over with rheumatoid arthritis</td>
<td>1</td>
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</tr>
<tr>
<td>NICE 2012 menu ID: NM55</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ongoing management</td>
<td>10</td>
<td>40–90%</td>
</tr>
<tr>
<td>RA002. The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 15 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NICE 2012 menu ID: NM58</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

RA – rationale for inclusion of indicator set

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

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

RA indicator 001 (NICE 2012 menu ID: NM55)

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

**RA 001.1 Rationale**

The RA register includes patients aged 16 or over with established and recent-onset disease and in whom there is a definite diagnosis of RA, irrespective of evidence of positive serology and current disease activity status.
When creating the register from historical diagnoses, the diagnosis may have been made by either a GP or a specialist. In future, it is anticipated that new diagnoses will be made by a specialist.

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

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

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

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

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

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

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

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

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

RA indicator 002 (NICE 2012 menu ID: NM58)

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

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

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

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

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

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

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

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

PC – rationale for inclusion of indicator set

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

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

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

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

Analysis (ADA) as examples of good practice. Evidence suggests that over 60 per cent of practices across the UK now use GSF to some degree to improve provision of palliative care by their primary care team.

The introduction of the GSF\textsuperscript{79} to primary care and its associated audit tool, the ADA, are associated with a considerable degree of research and evaluation. The GSF provides ideas and tools that help contractors to focus on implementing high quality patient-centred care.

**PC indicator 001**

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

**PC 001.1 Rationale**

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

Identifying patients in need of palliative care, assessing their needs and preferences and proactively planning their care, are the key steps in the provision of high quality care at the end of life in general practice. This indicator set is focused on the maintenance of a register (identifying the patients) and on regular multidisciplinary meetings where the team can ensure that all aspects of a patient’s care have been assessed and future care can be co-ordinated and planned proactively\textsuperscript{80}.

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

1. Their death in the next 12 months can be reasonably predicted (rather than trying to predict, clinicians often find it easier to ask ‘the ‘surprise question’ - ‘Would I be surprised if this patient were still alive in 12 months?’)
2. They have advanced or irreversible disease and clinical indicators of progressive deterioration and thereby a need for palliative care e.g. they have one core and one disease specific indicator in accordance with the GSF Prognostic Indicators Guidance (see QOF section of the GSF website)
3. They are entitled to a DS 1500 form (the DS 1500 form is designed to speed up the payment of financial benefits and can be issued when a patient is considered

\textsuperscript{79} GSF. \url{http://www.goldstandardsframework.org.uk/}

\textsuperscript{80} NAO EoLc Report. ‘In one PCT 40 per cent of patients who died in hospital in October 2007 did not have medical needs which required them to be treated in hospital, and nearly quarter of these had been in hospital for over a month’. November 2008.
to be approaching the terminal stage of their illness. For these purposes, a patient is considered as terminally ill if they are suffering from a progressive disease and are not expected to live longer than six months).

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

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

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

**PC indicator 002W**

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

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

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

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

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

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

Public health domain introduction

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

The additional services indicators, within this domain either:

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

2. follow the format of the clinical domain indicators.

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

Format

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

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

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

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

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial diagnosis</td>
<td>10</td>
<td>40–90%</td>
</tr>
</tbody>
</table>

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

NICE 2011 menu ID: NM26

CVD-PP – rationale for inclusion of indicator set

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

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

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

CVD-PP 001.1 Rationale

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

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

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

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

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

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

81 NICE clinical guideline CG67. Lipid modification. www.nice.org.uk/guidance/CG67
The newer risk score QRISK has the advantage of including other variables, such as measures of social deprivation, ethnicity and family history. QRISK uses data from UK general practice databases.

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

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

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

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

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

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

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

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

See [www.npci.org.uk](http://www.npci.org.uk) for more information about explaining risk.

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

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

- smoking status
- alcohol consumption
- BMI or other measures of obesity (see the NICE clinical guideline on Obesity[^66])
- fasting total cholesterol, LDL cholesterol, HDL cholesterol and triglycerides (if fasting levels are not already available)
- fasting blood glucose

renal function
liver function (transaminases)
TSH if dyslipidaemia is present.

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

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

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

Patients with the following conditions are excluded from this indicator:

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

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

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP001W. The percentage of patients aged 50 or over who have a record of blood pressure in the preceding 5 years</td>
<td>10</td>
<td>50–90%</td>
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<tr>
<td><em>NICE 2012 menu ID: NM61</em></td>
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</table>

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

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

#### BP 001W.1 Rationale

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

Detecting elevated blood pressure and, where indicated, treating it, is known to be an effective health intervention. Raised blood pressure is common if it is measured on a single occasion but with repeated measurement blood pressure tends to drop. Guideline recommendations for the diagnosis and treatment of hypertension\(^87\) are to be followed by practitioners when deciding on whether to treat raised blood pressure.

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

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

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

See indicator wording for requirement criteria.

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[http://guidance.nice.org.uk/CG34](http://guidance.nice.org.uk/CG34)
Obesity (OB)

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

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

The prevalence of obesity is a major PH challenge for the UK. In Wales, for example, 22 per cent of adults are obese88. In Scotland in 2010, 27.4 per cent of the adult population aged 16 or over and under the age of 65 were obese (BMI >30).

There is a substantive evidence base on the epidemiology of obesity and its association with poor clinical outcomes. In addition to the obvious associated disease burden such as inactivity, degenerative joint disease, lower employment and mood disorders, obesity is also a major contributory factor for some of the most common causes of death and disability in developed economies, most notably greater rates of diabetes89 and accelerated onset of CVD90. Obesity has therefore become a major health issue for the UK. The Foresight UK Tackling Obesities report 2007 estimated the cost to the UK of obesity to be £50 billion in 2050 at today’s prices.

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

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

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

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

89 Sullivan et al. Diabetes Care 2005; 28 (7): 1599-603
90 Gregg et al. JAMA 2005; 293 (15): 1868-74
Further information

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


**OB indicator 001**

The contractor establishes and maintains a register of patients aged 16 or over with a BMI ≥30 in the preceding 15 months

**OB 001.1 Rationale**
The register includes all patients whose BMI has been recorded in the practice as part of routine care. It is expected that this data will inform PH measures.

**OB 001.2 Reporting and verification**
See indicator wording for requirement criteria.
Smoking (SMOK)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Records</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| SMOK002. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 15 months  

*NICE 2011 menu ID: NM38* | 25     | 60–90%                 |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| SMOK004. The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months  

*NICE 2011 menu ID: NM40* | 12     | 40–90%                 |
| SMOK005. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 15 months  

*NICE 2011 menu ID: NM39* | 25     | 53-93%                 |

**Requirements for recording smoking status**

**Smokers**
For patients who smoke, smoking status should be recorded in the preceding 15 months for SMOK002.

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

Once a patient is over the age of 25 years (e.g. in the financial year in which they reach they age of 26 or in any year following that financial year) to be classified as a non-smoker they should be recorded as:
never smoked which is both after their 25th birthday and after the earliest diagnosis date for the disease which led to the patients inclusion on the SMOK002 register (e.g. one of the conditions listed on the SMOK002 register).

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

**SMOK indicator 002 (NICE 2011 menu ID: NM38)**

The percentage of patients with any of any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 15 months

**SMOK 002.1 Rationale**

**CHD**
Smoking is known to be associated with an increased risk of CHD.

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

ESC. European Guidelines. CVD Prevention in clinical practice.  
http://www.sign.ac.uk/guidelines/fulltext/97/index.html

**PAD**
PAD is associated with older age and with smoking. Cigarette smoking is a very important contributor to PAD and as such the management of PAD includes smoking cessation.

**Stroke or TIA**
There are few RCTs of the effects of risk factor modification in the secondary prevention of ischaemic or haemorrhagic stroke. However, inferences can be drawn from the finds of primary prevention trials that cessation of cigarette smoking be advocated.

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. The NICE clinical guideline on hypertension\textsuperscript{91} recommends that patients who smoke are offered advice and help to stop smoking.

**Diabetes**
The risk of vascular complications in patients with diabetes is substantially increased. Smoking is an established risk factor for cardiovascular and other diseases.

**COPD**
Smoking cessation is the single most effective and cost-effective intervention to reduce the risk of developing COPD and stop its progression.


GOLD Guidelines. \url{http://www.goldcopd.org/}

**Asthma**
There are a surprisingly small number of studies on smoking related asthma. Starting smoking as a teenager increases the risk of persisting asthma. One controlled cohort study suggested that exposure to passive smoke at home delayed recovery from an acute attack. Smoking reduces the benefits of inhaled steroids and this adds further justification for recording this outcome\textsuperscript{92}. There is also epidemiological evidence that smoking is associated with poor asthma control\textsuperscript{93}.

**Schizophrenia, bipolar affective disorder or other psychoses**
Patients with a serious mental illness are far more likely to smoke than the general population (61 per cent of patients with schizophrenia and 46 per cent of patients with bipolar disorder smoke compared to 33 per cent of the general population). Premature death and smoking related diseases, such as respiratory disorders and heart disease, are however, more common among patients with serious mental illness who smoke than in the general population of smokers\textsuperscript{94}.

See requirements for recording smoking status for further information.

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

For patients who smoke this recording is to be made in the preceding 15 months. Ex-smokers are to be recorded as described above. Those who have never smoked are to be recorded as such in the preceding 15 months up to and including the age of 25.


\textsuperscript{92} Tomlinson JE, McMahon AD, Chaudhuri R et al. Efficacy of low and high dose inhaled corticosteroids in smokers versus non-smokers with mild asthma. Thorax 2005; 60:282-7


\textsuperscript{94} McDonald C. Cigarette smoking in patients with schizophrenia. BJP 2000; 176: 596-7
The disease register for the purpose of calculating APDF for SMOK002 and SMOK005W is defined as the sum of the number of patients on the disease registers for each of the conditions listed in the indicator wording. Patients with one or more co-morbidities e.g. diabetes and CHD are only counted once.

**SMOK indicator 004 (NICE 2011 menu ID: NM40)**

The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months

**SMOK 004.1 Rationale**

Smoking remains the main cause of preventable morbidity and premature death, leading to an estimated annual average of 86,500 deaths between 1998 and 2002 in England\(^5\). It is the primary reason for the gap in healthy life expectancy between the rich and the poor\(^6\).

Smoking is the greatest single cause of avoidable mortality in Wales. One of the key themes identified in Our Healthy Future is the need to further reduce smoking and exposure to second-hand smoke, which has lead to the development of a Tobacco Control Action Plan for Wales, which aims to address these issues. A report on Tobacco and Health in Wales\(^7\) was published jointly by the Welsh Government and the Public Health Wales Observatory in June 2012. This detailed report provides a wide range of data on smoking in Wales to support the implementation of the Welsh Government’s Tobacco Control Action Plan for Wales\(^8\).

A wide range of diseases and conditions are caused by cigarette smoking, including cancers, respiratory diseases, CHD and other circulatory diseases, stomach and duodenal ulcers, ED and infertility, osteoporosis, cataracts, age-related macular degeneration and periodontitis (US DH and Human Services 2004).

Women who smoke during pregnancy have a substantially higher risk of spontaneous abortion (miscarriage) than those who do no smoke. Smoking can also cause complications in pregnancy and labour, including ectopic pregnancy, bleeding during pregnancy, premature detachment of the placenta and premature rupture of the membranes\(^9\).

Around 43 per cent of patients who smoke try to quit each year, often several times a year. Many of these attempts fail because they are made without treatment and the aim of this domain is to increase the proportion of quit attempts that succeed by

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\(^7\) Tobacco and Health in Wales http://www.wales.nhs.uk/sitesplus/922/page/59800

\(^8\) Tobacco Control Action Plan http://wales.gov.uk/topics/health/improvement/index/tobaccoplan/?lang=en

providing best available support and treatment. The one year continuous abstinence rate in untreated smokers who try to quit without help is about three per cent\textsuperscript{100}. There is evidence that when doctors and other health professionals advise on smoking cessation and particularly when they offer support and treatment, that people are more likely to quit.

Around four per cent of patients who quit without using either pharmacotherapy or behavioural support will remain abstinent at 12 months. With pharmacotherapy and brief supervision from a GP or other clinician, this would be about eight per cent. If a patient takes up the offer of referral to an NHS Stop Smoking Service or a specially trained member of staff directly employed by the contractor, such as a practice nurse, providing regular weekly support, the one year continuous abstinence rate doubles to about 15 per cent.

See SMOK005W.1 for guidance on 'support and treatment' and smoking cessation.

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

There is no APDF calculation for SMOK004.

**SMOK indicator 005 (NICE 2011 menu ID: NM39)**

The percentage of patients with any of any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 15 months.

**SMOK 005.1 Rationale**
This indicator relates to patients who are on the disease registers for CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, asthma and mental health who are recorded as current smokers.

See requirements for recording smoking status for further information.

In 2009, 21 per cent of the adult population of Great Britain were cigarette smokers. The Welsh Health Survey 2011 reported 23 per cent of the Welsh population were cigarette smokers. The overall prevalence of smoking has been at this level since 2007\textsuperscript{101}. At any one time, about 12 per cent of smokers intend to stop smoking in the last month\textsuperscript{102}.


Around 43 per cent of the population of England have tried to stop in the past year, but only two to three per cent of the population succeed in stopping.\(^{103}\)

There is good evidence to suggest that offering support and treatment is sufficient to motivate some smokers to attempt to stop who would not have done so with brief advice to quit alone.

For example, a Cochrane review that included 132 trials of nicotine replacement therapy (NRT), with over 40,000 people in the main analysis, found evidence that all forms of NRT made it more likely that a person's attempt to quit smoking would succeed. The chances of stopping smoking were increased by 50 to 70 per cent.\(^{104}\)

NHS Stop Smoking Services, combine psychological support and medication. Results for April 2008 to March 2009 showed that 671,259 people who had contact with the service had set a quit date. Four weeks later, 337,054 people had successfully quit (based on self-report) representing half of those who set a quit date.\(^{105}\)

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

The NICE public health guidance on smoking cessation\(^{106}\) states that healthcare professionals who advise on, or prescribe, NRT, varenicline or bupropion:

1. offer NRT, varenicline or bupropion, as appropriate, to patients who are planning to stop smoking
2. offer advice, encouragement and support, including referral to the NHS Stop Smoking Service (http://www.stopsmokingwales.com/home), to help patients in their attempt to quit
3. when deciding which therapies to use and in which order, discuss the options with the client and take into account:
   • whether a first offer of referral to the NHS Stop Smoking Service has been made
   • contra-indications and the potential for adverse effects
   • the client's personal preferences

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\(^{104}\) Stead LF, Perera R, Bullen C etc al. Nicotine replacement therapy for smoking cessation. Cochrane Database of Systematic Reviews. 2008. John Wiley and Sons, Ltd no.1


• the availability of appropriate counselling or support
• the likelihood that the client will follow the course of treatment
• their previous experience of smoking cessation aids.

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

1. offer behavioural counselling, group therapy, pharmacotherapy, or a combination of treatments that have been proven to be effective

2. ensure clients receive behavioural support from a person who has had training and supervision that complies with the 'Standard for training in smoking cessation treatments' or its updates

3. provide tailored advice, counselling and support, particularly to clients from minority ethnic and disadvantaged groups

4. provides services in the language chosen by clients, wherever possible.

For further information see NICE public health guidance 1 and 10 and the Primary Care Respiratory Society UK statement on managing smoking cessation in primary care.

Smoking cessation services in Wales are provided by Stop Smoking Wales, information on their services can be found at http://www.stopsmokingwales.com

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

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

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Public health domain – additional services

For contractors providing additional services the following indicators apply.

Please note exception reporting does not apply to those additional services indicators that do not have achievement thresholds.

Cervical screening (CS)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>CS001. The contractor has a protocol that is in line with national guidance agreed with the LHB for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate sample rates</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>CS002. The percentage of women aged 25 or over and who have not attained the age of 65 whose notes record that a cervical screening test has been performed in the preceding 5 years</td>
<td>11</td>
<td>45–80%</td>
</tr>
</tbody>
</table>

CS indicator 001

The contractor has a protocol that is in line with national guidance agreed with the LHB for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate sample rates

CS 001.1 Rationale

If a robust system for the management of cervical screening is not in place then this is an area of great risk for general practice. The policy may have been drawn up outside the practice and is recommended to be in line with national guidance.

See guidance on exception reporting in section CS 002.1 contractor guidance.

The contractors protocol could be in the form of a written policy covering the issues outlined in the indicator wording.

CS 001.2 Reporting and verification

See indicator wording for requirement criteria.

The relevant practice staff are to be aware of the policy and the LHB may require that the contractor can demonstrate how the systems operate.
CS indicator 002

The percentage of women aged 25 or over and who have not attained the age of 65 whose notes record that a cervical screening test has been performed in the preceding 5 years

CS 002.1 Rationale
This indicator is designed to encourage and incentivise contractors to continue to achieve high levels of uptake in cervical screening.

The contractor may be required to provide evidence of the number of eligible women, aged 25 or over and under the age of 65, who have had a cervical screening test performed in the last five years/60 months.

This indicator differs from all the other additional service indicators in that a sliding scale will apply between 45 and 80 per cent, in a similar way to the clinical indicators.

Exception reporting (as detailed in the clinical domain) will apply and specifically includes women who have had a hysterectomy involving the complete removal of the cervix.

The exception reporting rules regarding criteria A require that three separate invitations are offered to the patient before that patient can be recorded as ‘did not attend’. Therefore:

- In those areas where the first two invitations are sent via the central screening service, then contractors are responsible for offering the third invitation before exception reporting patients as DNA; or
- Where the central screening service sends out only one letter, then contractors are responsible for offering the second and third invitations before exception reporting patients as DNA.

The exception reporting criteria is not applicable to contractors that have opted to run their own call/recall system. These contractors will still be required to offer all three invitations directly in order to meet the DNA criteria. Copies of the letters sent by the contractor may be required for assessment purposes.

Women can choose to withdraw from the national screening programme. As the indicator requires that screening is delivered every five years, in order for a woman to be exception reported for this period, criteria G which requires that a discussion has taken place between the patient and the practitioner before ‘informed dissent’ can be recorded.

Women who withdraw from cervical screening call/recall will receive no further offers of screening from the central screening service.

Wales. NHS Cervical Screening Wales Programme.  
http://www.screeningservices.org.uk/csw/
CS 002.2 Reporting and verification
See indicator wording for requirement criteria.

The LHB may require that the contractor can provide a computer print-out showing the number of eligible women on the contractor list, the number exception reported and the number who have had a cervical screening test performed in the preceding five years. Contractors can exception report patients in the same way as the clinical indicators and the LHB may enquire how patients who are exception reported are identified and recorded.

Influenza (FLU)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>FLU001W. The percentage of the registered population aged 65 years of more who have had influenza immunisation in the preceding 1 August to 31 March</td>
<td>5</td>
</tr>
<tr>
<td>Range 55% - 75%</td>
<td></td>
</tr>
<tr>
<td>FLU002W. The percentage of patients aged under 65 years included in (any of) the registers for CHD, COPD, Diabetes or Stroke who have had influenza immunisation in the preceding 1 August to 31 March</td>
<td>15</td>
</tr>
<tr>
<td>Range 45% - 65%</td>
<td></td>
</tr>
</tbody>
</table>

FLU indicator 001
The percentage of the registered population aged 65 years of more who have had influenza immunisation in the preceding 1 August to 31 March

FLU 001.1 Rationale
This is a current recommendation from the CMO and the JCVI

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

FLU Indicator 002
The percentage of patients aged under 65 years included in (any of) the registers for CHD, COPD, Diabetes or Stroke who have had influenza immunisation in the preceding 1 August to 31 March
FLU 002.1 Rationale

This is a current recommendation from the CMO and the JCVI

FLU 002.2 Reporting and verification
See indicator wording for requirement criteria.
Section 5: Medicines Management Domain

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

'xxx.1 Rationale'
This sub section explains why the indicator has been selected. Wherever possible, the evidence source is described and if available, a web address (hyperlink in an electronic version of this guidance) is provided. When available, national guidelines have been used as the main evidence source, but individual papers are also quoted.

In some areas, more extensive information is provided. The aim is to achieve a balance of providing helpful information without attempting to provide a textbook of medicine or replicating guidelines.

'xxx.2 Reporting and verification'
Annex D to the SFE sets out the requirements in relation to verification. The contractor is required to ensure that it is able to provide any information that the LHB may reasonably request of it to demonstrate that it is entitled to each achievement point to which it says it is entitled and the contractor is required to make that information available to the LHB on request. In verifying that an indicator has been achieved and information correctly recorded, the LHB may chose to inspect the output from a computer search that has been used to provide information on the indicator, or a sample of patient records relevant to the indicator, or view appropriate procedure manuals or protocol documents.

See section one for full details on reporting and verification.
## Medicines Management

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
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</thead>
<tbody>
<tr>
<td>MED006W</td>
<td>The practice meets the LHB prescribing adviser at least twice per year, has agreed up to three actions related to prescribing and subsequently provided evidence of change</td>
</tr>
<tr>
<td>MED007W</td>
<td>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%</td>
</tr>
</tbody>
</table>

### MED indicator 006W

The practice meets the LHB prescribing adviser at least annually, has agreed up to three actions related to prescribing and subsequently provided evidence of change.

#### MED 006W.1 Rationale

Normally, improvements should be demonstrated in all three areas. However, if good reasons can be presented by the practice for not having achieved improvements, then the practice can still achieve this indicator. The practice should be able to provide written support from the LHB prescribing adviser for its reasons for not achieving the areas in question.

If the LHB prescribing adviser is unable to visit within the year, then the practice is exempt. The practice should provide written confirmation from the PCO prescribing adviser that he or she has been unable to visit within the relevant year.

#### MED 006W.2 Reporting and Verification

Actions and improvements may be discussed during an assessment visit or with the LHB prescribing advisor.

### MED indicator 007W

A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed four or more repeat medicines.

Standard 80%

#### MED 007W.1 Rationale

Medication is by far the most common form of medical intervention. Four out of five people over 75 years take a prescription medicine and 36% are taking four or
more. However, we also know that up to 50% of drugs are not taken as prescribed, many drugs in common use can cause problems and that adverse reactions to medicines are implicated in 5-17% of hospital admissions.

Involving patients in prescribing decisions and supporting them in taking their medicines is a key part of improving patient safety, health outcomes and satisfaction with care. Medication review is increasingly recognised as a cornerstone of medicines management. It is expected that at least a Level 2 medication review will occur, as described in the Briefing Paper.

http://www.npc.nhs.uk/review_medicines/intro/resources/room_for_review.pdf

The underlying principles of any medication review, whether using the patient’s full notes or face to face are:

1. All patients should have the chance to raise questions and highlight problems about their medicines.
2. Medication review seeks to improve or optimise impact of treatment for an individual patient.
3. The review is undertaken in a systematic way by a competent person.
4. Any changes resulting from the review are agreed with the patient.
5. The review is documented in the patient’s notes.
6. The impact of any change is monitored.

Medicines DO NOT include dressings and emollients but would include topical preparations with an active ingredient such as steroid creams and ointments and hormone preparations.

**MED 007W.2 Reporting and Verification**

A survey of medication review should be undertaken. This could be a computerised search and print out or a survey of fifty records of patients on four or more medications. An inspection of records should be carried out during an assessment visit.

The assessors should ask the staff to demonstrate how the system works and in particular how an annual review is ensured.

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110 Medicines and Older People – Supplement to the National Service Framework for Older People, 2001
Section 6: Cluster Network Development Domain
Strategic context

The delivery of local health services and more care in the community is a key element of LHB’s 3 year service delivery plans.

A Plan for a Primary Care Service for Wales sets out a vision for the development of primary care services to March 2018. The aim is to develop a more ‘social’ model of health which promotes physical, mental and social wellbeing, rather than just the absence of ill health. This approach, which draws in all the relevant public and voluntary sector services to support individuals, recognises the skills and resources patients themselves bring to achieving the outcomes that matter most to them.

The primary care plan has five priority areas for action (planning care locally; improving access and quality; equitable access; a skilled local workforce; strong leadership) and will help to reshape the NHS, developing and increasing the primary care workforce to provide the majority of care close to people’s homes together with accelerating the transfer of services from the hospital to the community and improving the way people can access services.

GPs will continue to play a pivotal role providing leadership and working directly with those patients with complex needs and ensuring continuity of care through better coordination of all available resources to deliver patient centred objectives.

It is vital practices plan to ensure the sustainability of their own services and strengthen GP cluster networks [referred to as a cluster network] as the lead agents for change in the delivery of the Welsh Government’s strategic aims to meet individuals’ needs close to their home.

Key aims

In the second year of the Cluster Network Development Programme (2015-16), we will build on the progress made in 2014/15 and:

- Ensure the sustainability of core services with appropriate risk management and actions to address local needs, including improved access to services.
- Strengthen GP multi-disciplinary team working and inform local workforce strategies.
- Further develop horizontal integration to support sustainable general practice and new models of care led by local teams (for example, developments may include cross referral for clinical care; federations of GP practices; shared administrative support; full practice mergers)

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A GP cluster network is defined as a cluster or group of GP practices within the Local Health Board’s area of operation as previously designated for QOF QP purposes
Further develop local needs assessment working closely with colleagues in public health and developing a shared understanding of priorities across health and social care services.

Develop more effective collaborative working with community services (including nursing, local authority and third sector) to improve the coordination and quality of care and to optimise the availability of professional skills. Prioritise signposting to the most appropriate professional or self care.

Further develop 2014/15 cluster network actions where appropriate.

Key objectives

To update the practice needs assessment and prioritise actions in the Practice Development Plan, including proposals at cluster network and local health board (LHB) levels.

Improve systems of clinical governance through action to address priority areas in the CGSAT, such as vulnerable adults, adults with a learning disability and safeguarding children.

Develop the maturity of cluster networks to drive improvement of local services through clear prioritised actions to inform the direction of resources and management of delegated budgets and community staff where appropriate.

Deliver quality improvement through continuing work in the three national priority areas:
  - Prevention and early diagnosis of cancer.
  - End of life care.
  - Minimising the harms of polypharmacy.

The development and delivery of local health services to support more care in the community is a key element of LHB’s 3 year service delivery plans.

Annex 1 sets out the role of LHBs in supporting and engaging with GP practices and clusters in the development and delivery of local health care.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Development Plan</td>
<td></td>
</tr>
<tr>
<td>CND 001W. The contractor updates the review of local need and the provision of services within the practice developing priorities for action to inform the production of a Practice Development Plan (PDP), taking into account the work from the national and locally agreed priority areas from the previous year.</td>
<td>30</td>
</tr>
</tbody>
</table>

The contractor updates the PDP (utilising the proforma at Annex 2) to assist practice analysis and planning and to inform discussions at GP cluster network meetings.

The contractor participates in meetings with other health professionals twice during the year to develop the local multi disciplinary team (MDT) with the aim of improving the coordination and quality of care and optimising the availability of professional skills. Any MDT improvement actions to be identified by 31 March 2016 and to be considered for inclusion in a revised future PDP, if not already
addressed by this date. The contractor to consider whether any MDT improvement actions need to be discussed at cluster level.

The contractor ensures patients have the opportunity to contribute to the development of priorities through a patient participation group or other formal / informal feedback obtained from patients and for arrangements to be in place to collate the views of patients. Any patient experience improvement actions to be identified by 31 March 2016, or actioned during the year if early identification allows, and to be considered for inclusion in a revised future PDP. The contractor to consider whether any patient experience improvement actions can be more effectively delivered at cluster level and, where appropriate, to include in cluster network discussions.

The full PDP to be shared with the LHB by 30 June 2015. In exceptional cases where practices need to redact any information, refer to supporting guidance.

The PDP objectives and priorities (at page 22 /25 Annex 2) to be published on My Local Health Service by 30 September 2015. The LHB will post the PDP objectives and priorities on My Local Health Service. Refer to supporting guidance.

<table>
<thead>
<tr>
<th>Cluster Network Action Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>CND 002W. The contractor participates in a cluster network meeting to discuss with peers the health needs and service development priorities for the population served by the cluster network, including relevant issues identified within the individual PDP which can be most effectively addressed as a cluster network action.</td>
</tr>
<tr>
<td>The cluster network action plan (based on the proforma at Annex 3) will address the following key areas:</td>
</tr>
<tr>
<td>a. Access arrangements - comparison of core access arrangements; exploration of adjuvants to access (including telephone arrangements); user experience; consider Welsh Language provision and the other language needs of the practice; the impact of My Health On Line where it is available to practices; responding to urgent requests and same day requests from care homes, Welsh Ambulance Services and hospital emergency departments.</td>
</tr>
<tr>
<td>b. Consideration of how resources can be used most effectively to provide local access to services to which patients require frequent access (such as phlebotomy, anticoagulation management ECG , spirometry) and those that support effective self management ( such as structured diabetes, education and pulmonary rehab, acute illnesses.. These discussions will include the extent to which new resources may be required to deliver improved local services to patients and included in the cluster network action plan.</td>
</tr>
<tr>
<td>c. Mapping of local GP services to highlight where services are delivered across practices (for example, contraceptive services, minor surgery) with particular reference to vulnerable groups (including asylum seekers, homeless, and patients with learning disabilities.</td>
</tr>
<tr>
<td>d. Consideration of how new approaches to the delivery of primary care might aid service delivery and ensure sustainability of local services. Developments might include new technologies, development of clinical</td>
</tr>
</tbody>
</table>
The contractor participates in a cluster network meeting with LHB community networks and other service users at least once a year to improve the coordination and quality of care, access to wider community assets and responding to service user needs. Any improvement actions to be identified and to be considered for inclusion in a future revised cluster network action plan.

The contractor participates in the completion of a cluster network action plan (at Annex 3).

The contractor agrees the contents of a cluster network action plan to deliver against shared local objectives.

The LHB network lead or nominated person will be responsible for collating and ensuring the cluster network action plan is completed by 30 September 2015.

The cluster network members are responsible for the agreement and delivery of the cluster network action plan.

The cluster network action plan (at Annex 3) to be revised and shared with the LHB by 30 September 2015.

The cluster network action plan (at Annex 3) to be published on My Local Health Service by 31 December 2015. The LHB will post the cluster network action plan on My Local Health Service. Refer to supporting guidance.

The cluster network action plan will be subject to review at each meeting as outlined below in indicator CND 003W.

### Implementation and delivery of the Cluster Network Action Plan

CND 003W. The contractor participates in three cluster network meetings to review the implementation and delivery of the cluster network action plan.

The cluster network meetings will be facilitated by the LHB network lead or nominated person. This will ensure effective communication between the cluster network and the LHB and, where appropriate, the alignment on progress against cluster priorities outlined in the cluster network action plan with LHB strategic and operational priorities.

The cluster network action plan is a dynamic plan and will be updated to reflect the agreed outcomes of each cluster network meeting.

### Cluster Network Annual Report

<table>
<thead>
<tr>
<th>25</th>
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</table>
### CND 004W
The contractor participates in one cluster network meeting to develop and agree a cluster network annual report (at Appendix 4) and to share with the LHB by 31 March 2016.

The cluster network annual report to be published on My Local Health Service by 30 June 2016. The LHB will post the cluster network annual report on My Local Health Service. Refer to supporting guidance.

### Clinical Governance

CND 005W. The contractor updates the Clinical Governance Practice Self Assessment Toolkit \(^{112}\) (CGPSAT) and to confirm completion and submission to the LHB by 31 March 2016. Information on the completion of CGPSAT is at Appendix 5.

The contractor participates in a review of the appropriate healthcare standards in relation to the promotion of safeguarding vulnerable adults; adults with a learning disability; safeguarding children. Practices are expected to achieve at least level 2 CGPSAT assurance. Any improvement actions to be identified by 31 March 2016, or actioned during the year if early identification allows.

The contractor will include appropriate actions resulting from completion of the CGSAT within a revised future PDP and will consider whether any issues need to be discussed at cluster level.

### Participating in General Practice National Priority Areas

CND 006W: Understanding cancer care pathways and identifying opportunities for service improvement (guidance at Appendix 6).

The contractor will:

1. Review the care of all patients newly diagnosed between 1\(^{st}\) January 2015 and 31\(^{st}\) December 2015 with lung (including mesothelioma) and digestive system cancer using a Significant Event Analysis tool.

2. Review the care of all patients newly diagnosed with ovarian cancer between 1\(^{st}\) January 2015 and 31\(^{st}\) December 2015 using a Significant Event Analysis tool.

3. Summarise learning and actions to be shared with the network and the wider LHB.

4. Identify and include any relevant actions to be addressed in the PDP

5. Summarise themes and actions for discussion at cluster network meetings and share information with the LHB as required. This should be achieved through completion of the proforma (at Appendix 6a)

The outcomes of this work to be included in the cluster network annual report at indicator CND 004W

\(^{112}\) [http://www.wales.nhs.uk/sitesplus/888/page/44038](http://www.wales.nhs.uk/sitesplus/888/page/44038)
It is anticipated the cluster network will discuss the learning from this work and agree necessary actions towards the end of the contract year.

The contractor to provide a statement to the LHB, by 31 March 2016, they have identified outcomes from the cluster analysis to be considered for inclusion in the cluster network annual report and any relevant actions to be included in a revised future PDP.

CND 007W: Improving end of life care (guidance at Annex 7).

1. Identify all deaths occurring between 1st January 2015 and 31st December 2015.

Use a significant event analysis approach to assess delivery of end of life care (with a particular focus on continuity of care). This analyses should, where possible, include a review of:
- contacts by the multi-disciplinary team in the last two weeks of life;
- the completion of DNACPR forms;
- completion of out of hours handover forms;
- the availability of “Just in Case” boxes and
- emergency admissions of patients at the end of life.

2. This significant event analyses should be carried out for a minimum of 2/1000 registered patients whose deaths occurred between 1st January 2015 and 31st December 2015.

3. Identify any learning and actions required which should be linked into the Practice Development Plan.

4. Summarise themes and actions for discussion at cluster network meetings and share information with the LHB as required. This should be achieved through completion of the proforma (at Annex 7a)

The outcomes of this work to be included within the GP Cluster Network Annual Report at indicator CND 004W.

It is anticipated the cluster network will discuss the learning from this work and agree necessary actions towards the end of the contract year.

The contractor to provide a statement to the LHB, by 31 March 2016, that they have identified outcomes from the cluster analysis to be considered for inclusion in the cluster network annual report and any relevant actions to be included in a revised future PDP.

CND 008W: Minimising the harms of polypharmacy (guidance at Annex 8)

The contractor will:
1. Identify and record number the % of patients aged 85 years or more receiving 6 or more medications (excluding dressings etc.)

2. Undertake face to face medication reviews, using the “No Tears” approach or similar tool as agreed within the cluster, for at least 60% of the cohort defined in 1 above (for a minimum number equivalent to 5/1000 registered patients. If the minimum number of reviews cannot be undertaken because of the small size of the cohort defined in 1 above, consider reducing the age limit until the minimum number is reached)

3. Identify and include any relevant actions to be addressed in the PDP.

4. Summarise themes and actions for review with the cluster network and share information with the LHB as required.

The outcomes of this work to be included within the cluster network annual report at indicator CND 004W.

It is anticipated that the cluster network will discuss the learning from this work and agree necessary actions towards the end of the contract year, building on the work already developed from the 2014/15 analysis.

The contractor to provide a statement to the LHB, by 31 March 2016, they have identified outcomes from the cluster analysis to be considered for inclusion in the cluster network annual report and any relevant actions to be included in the PDP.

Total points 160
CND 001W: Practice Development Plan

The contractor updates the review of local need and the provision of services within the practice, developing priorities for action to inform the production of a Practice Development Plan taking into account the work from the national and locally agreed priority areas from the previous year.

The contractor participates in meetings with other health professionals twice during the year to develop the local multidisciplinary team with the aim of improving the coordination and quality of care and optimising the availability of professional skills. Any multidisciplinary team improvement actions will be identified by 31 March 2016, and to be considered for inclusion in a revised future PDP, if not already addressed by this date. The contractor will consider whether any multidisciplinary team improvement actions need to be discussed at cluster level.

The contractor ensures patients have the opportunity to contribute to the development of priorities through a patient participation group or other formal / informal feedback obtained from patients and for arrangements to be in place to collate the views of patients. Any patient experience improvement actions will be identified by 31 March 2016 or actioned during the year if early identification allows and to be considered for inclusion in a revised future PDP. The contractor will consider whether any patient experience improvement actions can be more effectively delivered at cluster level and, where appropriate, to include in cluster network discussions.

The full Practice Development Plan to be shared with the LHB by 30 June 2015. In exceptional cases, practices may need to redact information.\(^{113}\)

The PDP objectives and priorities (at pages 22/25 Annex 2) to be published on My Local Health Service by 30 September 2015. The LHB will be responsible for posting the PDP objectives and priorities on My Local Health Service.

CND 001W.1 Rationale

This indicator builds on the 2014/15 indicator, informs practice development and ensures that services are appropriate for the population served. The outcomes of this analysis will inform discussions at cluster network meetings.

The indicator also reflects the aim to strengthen the local multidisciplinary team through engagement in two meetings during the year with the aim of improving the coordination and quality of care and optimising the availability of professional skills, and builds on the 2014/15 indicator to ensure patients have the opportunity to

\(^{113}\) In exceptional cases if a practice considers that some information in the PDP is commercially in confidence that information may be redacted. Redacted information however should not include information detailed in the workforce / workload demand sections.
contribute to the development of priorities through a patient participation group or other formal / informal feedback. The outcomes of the analysis of this work will also inform discussions at cluster network.

The indicator also reflects the aim to improve transparency and recognition of the work undertaken in General Practice through sharing the full PDP with the LHB (in exceptional cases information may be redacted) and publishing PDP objectives and priorities My Local Health Service.

CND 001W.2 Reporting and Verification

The Practice Development Plan will be updated and shared with the LHB by 30 June 2015.

The contractor will participate in meetings with the other health professionals twice during the year. The contractor will identify any multi-disciplinary improvement actions by 31 March 2016 (if not already addressed by this date) and to consider any actions for inclusion in a revised future Practice Development Plan and whether any actions need to be discussed at cluster network level. The MDT may include, for example, a health visitor; a midwife; a district nurse; a cancer nurse specialists; a social worker; a pharmacist. The contractor will be responsible for inviting multi-disciplinary team members to meetings. The contractor should not be penalised if all MDT members (or an appropriate deputy) cannot attend meetings. The contractor should be able to evidence any MDT attendance difficulties. For example, minutes of meetings with apologies noted or an anonymised copy of evidence of meeting invite (e.g. email/ telephone/ letter). If it is clear the contractor has made no reasonable effort to arrange and hold two MDT meetings no points should be awarded. If the contractor has arranged and held only one MDT meeting and has made no reasonable effort to arrange another MDT meeting, no points should be awarded. Notes of the MDT meeting, which should identify MDT members in attendance, may be used as evidence for payment.

The contractor will identify any patient experience improvement actions by 31 March 2016 (or to action during the year if early identification allows) and to consider any actions for inclusion in a revised future Plan. The contractor should be able to outline the patient feedback process for collating views on the development of priorities. Patient feedback may include patient participation groups and patient experience questionnaires. If the contractor cannot evidence the process through which the views of patients are collated, no points should be awarded.

The PDP objectives and priorities (at pages 22/ 25 Annex 2) to be published on My Local Health Service by 30 September 2015. LHBs will be required to forward copies of the PDP objectives and priorities to Welsh Government for uploading to My Local Health Service. LHBs will need to ensure that any information considered to be “commercially in confidence” is redacted. [In exceptional cases if a practice considers that some information in the PDP is commercially in confidence that information may be redacted. Redacted information however should not include information detailed in the workforce / workload demand sections as this information is necessary for the development of local service development plans.]
CND 002W: Network Action Plan

The contractor participates in a cluster network meeting to discuss with peers the health needs and service development priorities for the population served by the cluster network, including relevant issues identified within the individual Practice Development which can be most effectively addressed as a cluster network action.

The contractor participates in a cluster network meeting with LHB community networks and other service users at least once a year to improve the coordination and quality of care, access to wider community assets and responding to service user needs. Any improvement actions to be identified and to be considered for inclusion in a future revised cluster network action plan.

The contractor participates in the development of cluster network priorities and agrees the contents of a cluster network action plan to deliver against shared local objectives. The cluster network action plan will be revised and shared with the LHB by 30 September 2015.

The cluster network action plan will be published on My Local Health Service by 31 December 2015. The LHB will post the cluster network action plan on My Local Health Service.

The cluster network action plan will be subject to review at each meeting as outlined below in indicator CND 003W.

CND 002W.1 Rationale

This indicator builds on the 2014/15 indicator and aims to strengthen cluster networks in the delivery of the Welsh Government’s strategic aims to meet individuals’ needs close to their set out in the Welsh Government’s A Plan for a Primary Care Service for Wales.

The indicator also aims to develop more effective collaborative working with community services and other services users (including, for example, community nursing, local authority / social services; third sector; optometrists; audiologists; pharmacists; ) to improve the coordination and quality of care and to optimise the availability of professional skills. The indicator supports improved transparency through sharing the cluster network action plan with the LHB and publishing the action plan on My Local Health Service.

CND 002W.2 Reporting and Verification

The cluster network action plan will be revised and shared with the LHB by 30 September 2015.

The contractor and the practice manager / senior administrative employee will attend the (GP) cluster network meeting and to contribute to discussions agreeing the cluster network action plan. GP cluster networks leads and LHB cluster network
leads will agree agenda setting. Notes of the cluster meeting may be used as evidence of the meeting. The cluster network meeting will be facilitated by the LHB network lead. If the contractor or practice manager (or nominated deputy) does not attend the meeting facilitated by the LHB without any reasonable cause, no points will be awarded.

The contractor and the practice manager / senior administrative employee will attend the (LHB) cluster network meeting with LHB community networks and other service users at least once a year. Any improvement actions to be identified and to be considered for inclusion in a future revised cluster network action plan. The LHB network lead or nominated person will facilitate the cluster meeting. If the contractor or practice manager (or nominated deputy) does not attend the meeting facilitated by the LHB without any reasonable cause no points will be awarded.

The cluster network action plan will be published on My Local Health Service by 31 December 2015. LHBs will be required to forward a copy of the cluster network action plan to Welsh Government for uploading to My Local Health Service.

**CND 003W: Implementation and delivery of the GP Cluster Network Action Plan.**

The contractor participates in three cluster network meetings to review the implementation and delivery of the cluster network action plan. GP cluster networks leads and LHB cluster network leads will agree agenda setting.

The cluster network meetings will be facilitated by the LHB network lead or nominated person. This will ensure effective communication between the cluster network and the LHB and, where appropriate, the alignment on progress against cluster priorities outlined in the cluster network action plan with LHB strategic and operational priorities.

The cluster network action plan is a dynamic plan and will be updated to reflect the agreed outcomes of each cluster network meeting.

**CND 003W.1 Rationale**

This indicator builds on the 2014/15 indicator and aims to strengthen cluster networks in the delivery of the Welsh Government’s strategic aims to meet individuals’ needs close to their set out in the Welsh Government’s A Plan for a Primary Care Service for Wales.

**CND 003W.2 Reporting and Verification**

The contractor will participate in three cluster network meetings to review the implementation and delivery of the cluster network action plan. Notes of the cluster network meetings may be used as evidence for the meetings. The LHB network lead or nominated person will facilitate the cluster meetings. If the contractor or practice manager (or nominated deputy) does not attend the three cluster meeting facilitated by the LHB without any reasonable cause, no points will be awarded.
CND 004W: Cluster Network Annual Report

The contractor participates in one cluster network meeting to develop and agree a cluster network annual report and to share with the LHB by 31 March 2016.

The cluster network annual report is to be published on My Local Health Service by 30 June 2016. The LHB will post the cluster network annual report on My Local Health Service.

CND 004W.1 Rationale

This indicator builds on the 2014/15 indicator and aims to strengthen cluster networks in the delivery of the Welsh Government’s strategic aims to meet individuals’ needs close to their set out in the Welsh Government’s A Plan for a Primary Care Service for Wales.

CND 004W.2 Reporting and Verification

The Cluster Network Annual Report will be agreed and shared with the LHB by 31 March 2016.

The contractor will participate in one cluster network meeting to develop the Cluster Network Annual Report. The LHB network lead or nominated person will facilitate the cluster meetings. If the contractor or practice manager (or nominated deputy) does not attend the cluster meeting facilitated by the LHB without any reasonable cause, no points will be awarded.

The cluster network annual report is to be published on My Local Health Service by 30 June 2016. LHBs will be required to forward a copy of the cluster network action plan to Welsh Government for uploading to My Local Health Service

CND 005W: Clinical Governance

The contractor will updates the Clinical Governance Practice Self Assessment Toolkit (CGPSAT) and confirm completion and submission to the LHB by 31 March 2016.

The contractor will participates in a review of the appropriate healthcare standards in relation to the promotion of safeguarding vulnerable adults; adults with a learning disability; safeguarding children. Practices are expected to achieve at least level 2 CGPSAT assurance. Any improvement actions to be identified by 31 March 2016, or actioned during the year if early identification allows.

The contractor will include appropriate actions resulting from completion of the CGSAt within a revised future PDP and will consider whether any issues need to be discussed at cluster level.
CND 005W.1 Rationale

This indicator seeks to improve systems of clinical governance through action to address priority areas in the CGSAT, such as vulnerable adults, adults with a learning disability and safeguarding children.

CND 005W.2 Reporting and Verification

The contractor will update the Clinical Governance Practice Self Assessment Tool (CGSAT) and confirm completion and submission to the LHB by 31 March 2016.

The contractor will participate in a review of the appropriate healthcare standards in relation to the promotion of safeguarding vulnerable adults; adults with a learning disability; safeguarding children. The contractor will confirm whether level 2 CGPSAT assurance has been reached. If the contractor has not attained level 2 assurance, no points will be awarded.

The contractor will identify appropriate actions resulting from completion of the CGSAT within a revised future Practice Development Plan and will consider whether any issues need to be discussed at cluster network level.

CND 006W, 007W and 008W: Participating in General Practice National Priority Areas

The contractor will participate in the three General Practice National Priority Areas in accordance with the guidance set out at Annex 6 and 6a; Annex 7 and 7a; and Annex 8 and 8a

The contractor will identify improvement actions for each national priority area to be considered within the Practice Development Plan for 2016/17 and the cluster network action plan for 2016/17, as appropriate.

The Cluster Network Annual Report should reflect key findings from this work and indicate any actions to be delivered in 2016/17. The report should highlight what, if any, further developments are needed to support patient needs.

CND 006W, 007W and 008W 1 Rationale

The aim is to deliver quality improvement through continuing work in the three national priority areas: prevention and early diagnosis of cancer; end of life care; minimising the harms of polypharmacy.

CND 006W, 007W and 008W 2 Reporting and Verification
The contractor will complete the review of the three national priority areas and the outcomes of this work will be included in the cluster network annual report.

The cluster network will discuss the learning from these reviews and will agree necessary actions towards the end of the contract year.

The contractor will provide a statement to the LHB, by 31 March 2016, they have identified outcomes from the cluster analysis to be considered for inclusion in the cluster network annual report and any relevant actions to be included in a revised future Practice Development Plan.
Section 7: Queries process

Queries can be divided into three main categories:

1. those which can be resolved by referring to the guidance and/or FAQs
2. those which require interpretation of the guidance or Business Rules
3. those where scenarios have arisen which were not anticipated in developing guidance.

Within these categories, there will be issues relating to coding, Business Rules, payment, clinical issues and policy issues and in some cases the query can incorporate elements from each of these areas.

If there are queries which cross the above areas, the recipient will liaise with the other relevant parties in order to resolve/respond. In addition, where a query has been directed incorrectly, the query will be redirected to the appropriate organisation to be dealt with.

Where an issue relating to clinical indicators has arisen mid-year that cannot be resolved with simple clarification of the guidance, this will fall in to the NICE process of reviewing QOF indicators.

QOF queries should be directed as follows:

1. Queries relating to QOF Business Rules/coding should be sent to:
   NHS Wales Informatics Service via PrimaryCare.ServiceDesk@wales.nhs.uk

2. All other queries relating to QOF should in the first instance be sent to:
   Welsh Government via gmscontract@wales.gsi.gov.uk

NICE operate an online facility which allows stakeholders to comment on current QOF indicators. Comments will be used to review existing QOF indicators against set criteria which include:

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

Comments are fed in to a rolling programme of reviews and considered by the QOF Advisory Committee. The recommendations of the Committee will then be fed in to negotiations between NHS Employers and the GPC. The online facility is available on the NICE website\(^{114}\).

\(^{114}\) NICE website. QOF. [http://www.nice.org.uk/aboutnice/qof/qof.jsp](http://www.nice.org.uk/aboutnice/qof/qof.jsp)
Section 8: Exception reporting guidance

Purpose of guidance

Exception reporting was introduced into the QOF in 2004. It is intended to allow contractors to pursue the quality improvement agenda without being penalised for patient specific clinical circumstances or other circumstances beyond the contractor’s control which lead to failure to achieve the indicator. For example, where a medication cannot be prescribed due to a contra-indication or side-effect, where patients do not attend for review or where secondary care services are not available.

Since 2004, it became clear that a variety of interpretations and applications of the nationally defined exception reporting criteria are possible. NHS Employers and the BMA published guidance in October 2006 regarding what constitutes good practice in exception reporting. The 2006 guidance was designed to provide additional clarity, to the information contained in the QOF guidance, in order to help maintain a consistent approach to exception reporting.

From April 2013, the exception reporting guidance has been updated and supersedes any previous guidance issued. It is supplementary to the paragraphs included in section one of this document.

Principles

The overriding principles to follow in deciding to except a patient are that:

- The duty of care remains for all patients, irrespective of exception reporting arrangements.
- It is good practice for clinicians to review from time to time those patients who are excepted from treatment e.g. to have continuing knowledge of health status and personal health goals.
- The decision to exception report should be based on clinical judgement, relevant to the patient, with clear and auditable reasons coded or entered in free text on the patient record.
- There should be no blanket exceptions: the relevant issues with each patient should be considered by the clinician at each level of the clinical indicator set.

In each case where a patient is exception reported, in addition to recording what should be reported for payment purposes (in accordance with the Business Rules), the contractor should also ensure that the clinical reason for the exception is fully recorded in a way that can facilitate an audit in the patient record. This is both in order to manage the care of that particular patient and for the purpose of verification.
Definitions

There is an important distinction to be made between “exclusions” and “exceptions”. This guidance is about “exceptions”.

Exclusions are patients on a particular clinical register, but who for definitional reasons are not included in a particular indicator denominator. For example, an indicator (and therefore the denominator) may refer only to patients of a specific age group, patients with a specific status (e.g. those who smoke), or patients with a specific length of diagnosis, within the register for that clinical area.

Exceptions are patients who are on the disease register and who would ordinarily be included in the indicator denominator. However they are excepted from the indicator denominator because they meet at least one of the exception criteria set out in the SFE. Although patients may be excepted from the denominator, they should still be the recipients of best clinical care and practice.

The criteria under which a patient may be excepted from a QOF indicator are set out in the SFE and also in section one of this document.

Although the SFE sets out nine reasons why a patient may be exception reported, the national QOF achievement analysis systems (CQRS) identifies exception reporting against a limited number of codes. For example, criteria A and G are both coded as "informed dissent" or "patient refused". Any patient is only excepted once by the system for a given indicator, but any patient’s clinical record could contain more than one type of exception reporting Read code entered by the contractor. It is therefore not possible to extract completely accurate or meaningful data on exceptions broken down by each of the criteria defined in the SFE from the national systems. Therefore the HSCIC only reports the total numbers of patients excepted for each indicator.

For the purposes of managing the care of the patient and for subsequent audit and verification, it is important that the reason the patient meets one or more of the exception reporting criteria and any underlying clinical reason for this is recorded in the patient’s clinical record. For example, where a patient has not tolerated medication, the nature of the contraindication should be recorded in the patient’s notes as well as the exception reporting code applied.

Detailed guidance on exception reporting

Each of the nine criteria for exception reporting are detailed below:

A. Patients who have been recorded as refusing to attend review who have been invited on at least three occasions during the preceding 12 months.

Invitations to attend a review should be made to the individual patient and can be in writing or by telephone. This can include a note at the foot of the patient’s prescription requesting that they attend for review.
The three invitations need to have taken place within the financial year in question (e.g. 1 April 2014 to 31 March 2015 if applying to the year 2013/14). There should be three separate invitations at three unique periods of time. The only exception to this rule is indicator CS00, where the period in which the three invitations are sent reflects the timeframe of the indicator e.g. five years.

The telephone call invitation may lead to the application of exception criteria G, 'informed dissent', if the patient refuses to take up the invitation to attend.

The following are examples that are not acceptable as an invitation:

1. A generic invitation on the right hand side of the script to attend a clinic or an appointment e.g. influenza immunisation.
2. A notice in the waiting room inviting particular groups of patient to attend clinics or make appointments (e.g. influenza immunisation).

**Influenza immunisation indicators**

Exception reporting for influenza immunisation has caused some confusion because it is also remunerated through a DES. For the DES, payment is based on the number of at-risk patients immunised. The DES nevertheless requires the contractor to develop a proactive approach and a robust call and reminder system for the at-risk groups.

For QOF, the payment is based on the percentage of patients immunised in each relevant disease area. Exception reporting rules apply to the QOF indicators and patients need to have been personally invited on at least three occasions that year to be excluded from the denominator for achievement under criteria A.

**Cervical screening indicators**

Exception reporting (as detailed in the clinical domain) will apply and specifically includes women who have had a hysterectomy involving the complete removal of the cervix.

The exception reporting rules regarding criteria A require that three separate invitations are offered to the patient before that patient can be recorded as 'did not attend'. Therefore:

- In those areas where the first two invitations are sent via the central screening service, then contractors are responsible for offering the third invitation before exception reporting patients as DNA; or

- Where the central screening service sends out only one letter, then contractors are responsible for offering the second and third invitations before exception reporting patients as DNA.

The exception reporting criteria is not applicable to contractors that have opted to run their own call/recall system. These contractors will still be required to offer all
three invitations directly in order to meet the DNA criteria. Copies of the letters sent by the contractor may be required for assessment purposes.

Women can choose to withdraw from the national screening programme. As the indicator requires that screening is delivered every five years, in order for a woman to be exception reported for this period, criteria G which requires that a discussion has taken place between the patient and the practitioner before 'informed dissent' can be recorded.

Women who withdraw from cervical screening call/recall will receive no further offers of screening from the central screening service.

B. Patients for whom it is not appropriate to review the chronic disease parameters due to particular circumstances e.g. terminal illness, extreme frailty.

The overriding principle is that blanket exception reporting is not acceptable and individual decisions based on clinical judgment should be made.

It is not acceptable to exclude all patients above a certain age or all those with a particular diagnosis e.g. dementia or cancer. However, age, diagnosis, co-morbidity, health and functional status should be taken into account when deciding whether to exception report individual patients under this criteria.

In each individual case there is a question of degree which requires clinical judgement to be exercised.

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

Exception reporting is done automatically through the national achievement analysis system. Where the contractor has delivered the appropriate clinical standard within the timeframe for the indicator, the achievement would automatically override the exception.

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

The over-riding principle is that blanket exception reporting is not acceptable and each case is to be considered on its own merits, making a clinical judgment (see criteria B).

It is not acceptable to exclude all patients who are under the care of a consultant. Each case needs to be carefully considered and all reasonable efforts made to provide optimal care.

Even when a patient is under the care of a consultant only, the contractor should ensure it has evidence that all the requirements of the contract have been carried out. If this evidence is not available, the contractor should assume that the action
has not been carried out. The patient should not be exception reported on the basis that they are under the care of a consultant. The contractor should either fulfil the requirements of the relevant indicator(s) or obtain evidence from secondary care that the particular test/check has been carried out. Where the secondary care clinician, in agreement with the primary care clinician, has exercised clinical judgement and decided further action or testing is inappropriate, exception reporting will be allowed. This should be noted in the patient record.

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

The nature of the contra-indication, allergy or adverse drug reaction should be recorded in the patient record as well as the exception reporting code applied.

F. Where a patient has not tolerated medication.

The nature of the intolerance should be recorded in the patient record as well as the exception reporting code applied.

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

A personal contact or discussion should be documented in the patient’s record for this criteria to apply. This can include either face-to-face or telephone contact between a health professional and the patient.

Patients not responding to invitations to attend or failing to arrive at appointments cannot be exception reported under criteria G, e.g. DNA alone does not fulfil the criteria for informed dissent. Patients failing to respond after three invitations can be exception reported under criteria A.

The informed dissent should have been given in the period 1 April 2013 to 31 March 2014 if applying to the year 2013/14) (except cervical screening where a patient has withdrawn from the call and recall system).

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

The nature of the supervening condition should be recorded in the patient’s notes as well as the exception reporting code applied.

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

The contractor would be expected to explore fully with their LHB whether or not a
suitable investigative or secondary service could be commissioned for the patient prior to deciding to except them on the basis that the services was unavailable.
## Section 9: Glossary of terms

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<td>ABPI</td>
<td>Ankle Brachial Pressure Index</td>
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<td>ABPM</td>
<td>Ambulatory Blood Pressure Monitoring</td>
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<tr>
<td>ACCORD</td>
<td>Action to Control Cardiovascular Risk in Diabetes</td>
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<td>ACE-Inhibitor or ACE-I</td>
<td>Angiotensin Converting Enzyme Inhibitor</td>
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<td>ACR</td>
<td>Albumin:Creatinine Ratio</td>
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<td>ACS</td>
<td>Acute Coronary Syndrome</td>
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<td>ACTIVE-W</td>
<td>Atrial Fibrillation Clopidogrel Trial with Irbesartan for Prevention of Vascular Events</td>
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<td>ADA</td>
<td>After Death Analysis</td>
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<td>AED</td>
<td>Antiepileptic Drugs</td>
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<td>AF</td>
<td>Atrial Fibrillation</td>
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<td>AMA</td>
<td>American Medical Association</td>
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<td>APHO</td>
<td>Association of Public Health Observatories</td>
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<td>ARB</td>
<td>Angiotensin Receptor Blocker</td>
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<td>AST</td>
<td>Asthma</td>
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<td>ATC</td>
<td>Antithrombotic Trialists Collaboration</td>
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<td>BAFTA</td>
<td>Birmingham Atrial Fibrillation Treatment of the Aged</td>
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<td>BDI-II</td>
<td>Beck Depression Inventory, second edition</td>
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<td>BHSOC</td>
<td>British Hypertension Society</td>
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<td>BLS</td>
<td>Basic Life Support</td>
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<td>BMD</td>
<td>Bone Mass Density</td>
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<td>BMI</td>
<td>Body Mass Index</td>
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<td>BMA</td>
<td>British Medical Association</td>
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<td>BMJ</td>
<td>British Medical Journal</td>
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<td>Abbreviation</td>
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<tr>
<td>BNF</td>
<td>British National Formulary</td>
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<td>BP</td>
<td>Blood Pressure</td>
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<td>BPA</td>
<td>Bio-psychosocial Assessment</td>
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<td>BTS</td>
<td>British Thoracic Society</td>
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<td>CABG</td>
<td>Coronary Artery Bypass Grafting</td>
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<td>CHS</td>
<td>Child Health Surveillance</td>
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<td>CHADS$_2$</td>
<td>Congestive (HF) Hypertension Age (75 or over)</td>
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<td></td>
<td>Diabetes Stroke</td>
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<td>CI</td>
<td>Confidence Interval</td>
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<td>CKD</td>
<td>Chronic Kidney Disease</td>
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<td>CMO</td>
<td>Chief Medical Officer</td>
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<td>CND</td>
<td>GP Cluster Network Development</td>
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<td>CON</td>
<td>Contraception</td>
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<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
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<td>CPA</td>
<td>Care Programme Approach</td>
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<td>CQRS</td>
<td>Calculating Quality Reporting Service</td>
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<tr>
<td>CRP</td>
<td>C-Reactive Protein</td>
</tr>
<tr>
<td>CS</td>
<td>Cervical Screening</td>
</tr>
<tr>
<td>CVD</td>
<td>Cardiovascular Disease</td>
</tr>
<tr>
<td>CVD-PP</td>
<td>CVD Primary Prevention</td>
</tr>
<tr>
<td>DBP</td>
<td>Diastolic Blood Pressure</td>
</tr>
<tr>
<td>DCCT</td>
<td>Diabetes Control and Complications Trial</td>
</tr>
<tr>
<td>DH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>DEM</td>
<td>Dementia</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>DEP</td>
<td>Depression</td>
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<tr>
<td>DM</td>
<td>Diabetes Mellitus</td>
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<td>Did Not Attend</td>
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<tr>
<td>DRS</td>
<td>Diabetic Retinopathy Screening</td>
</tr>
<tr>
<td>DSM-IV</td>
<td>Diagnostic and Statistical Manual of Mental Disorders, fourth edition</td>
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<tr>
<td>DXA</td>
<td>Dual-Energy X-ray Absorptiometry</td>
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<td>ED</td>
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<tr>
<td>EHC</td>
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<tr>
<td>eGFR</td>
<td>Estimated Glomerular Filtration Rate</td>
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<tr>
<td>EOLC</td>
<td>End of Life Care</td>
</tr>
<tr>
<td>EP</td>
<td>Epilepsy</td>
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<tr>
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<td>European Prospective Investigation into Cancer</td>
</tr>
<tr>
<td>ERJ</td>
<td>European Respiratory Journal</td>
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<tr>
<td>ESR</td>
<td>Erythrocyte Sedimentation Rate</td>
</tr>
<tr>
<td>FBC</td>
<td>Full Blood Count</td>
</tr>
<tr>
<td>FEV&lt;sub&gt;1&lt;/sub&gt;</td>
<td>Forced Expiratory Volume in One Second</td>
</tr>
<tr>
<td>FVC</td>
<td>Forced Vital Capacity</td>
</tr>
<tr>
<td>GFR</td>
<td>Glomerular Filtration Rate</td>
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<td>GMP</td>
<td>Good Medical Practice</td>
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<td>GMS</td>
<td>General Medical Services</td>
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<tr>
<td>GOLD</td>
<td>The Global Initiative for Chronic Obstructive Lung Disease</td>
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<td>GP</td>
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<td>GPPAQ</td>
<td>GP Physical Activity Questionnaire</td>
</tr>
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<td>General Practice Research Database</td>
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<tr>
<td>GPwSI</td>
<td>GP with a Special Interest</td>
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<tr>
<td>GSF</td>
<td>Gold Standards Framework</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
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<tr>
<td>HAD-D</td>
<td>Hospital Anxiety and Depression Scale Depression Sub-Scale</td>
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<tr>
<td>HADS</td>
<td>Hospital Anxiety and Depression Scale</td>
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<td>HbA1c</td>
<td>Glycated Haemoglobin</td>
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<td>HBPM</td>
<td>Home Blood Pressure Monitoring</td>
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<td>HDA</td>
<td>Health Development Agency</td>
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<td>HF</td>
<td>Heart Failure</td>
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<td>HSCIC</td>
<td>NHS Health and Social Care Information Centre</td>
</tr>
<tr>
<td>HYP</td>
<td>Hypertension</td>
</tr>
<tr>
<td>IFCC</td>
<td>International Federation of Clinical Chemistry and Laboratory Medicine</td>
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<td>IUD</td>
<td>Intrauterine Device</td>
</tr>
<tr>
<td>IUS</td>
<td>Intrauterine System</td>
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<td>JBS</td>
<td>Joint British Societies</td>
</tr>
<tr>
<td>JCVI</td>
<td>Joint Committee on Vaccination and Immunisation</td>
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<tr>
<td>LARC</td>
<td>Long Acting Reversible Contraception</td>
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<td>LDL</td>
<td>Low Density Lipoprotein</td>
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<td>Local Medical Committee</td>
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<tr>
<td>LVSD</td>
<td>Left Ventricular Systolic Dysfunction</td>
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<tr>
<td>MAT</td>
<td>Maternity</td>
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<tr>
<td>MCM</td>
<td>Major Congenital Malformation</td>
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<td>MH</td>
<td>Mental Health</td>
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<tr>
<td>MI</td>
<td>Myocardial Infarction</td>
</tr>
<tr>
<td>mmHg</td>
<td>Millimetres of Mercury</td>
</tr>
<tr>
<td>mmol/l</td>
<td>Millimoles per Litre</td>
</tr>
<tr>
<td>MR</td>
<td>Modified Release</td>
</tr>
<tr>
<td>MRC</td>
<td>Medical Research Council</td>
</tr>
<tr>
<td>MRI</td>
<td>Magnetic Resonance Imaging</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>--------------</td>
<td>-----------</td>
</tr>
<tr>
<td>NAO</td>
<td>National Audit Office</td>
</tr>
<tr>
<td>NEJM</td>
<td>New England Journal of Medicine</td>
</tr>
<tr>
<td>NHANES</td>
<td>National Health and Nutrition Examination Survey</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
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<tr>
<td>LHB</td>
<td>Local Health Board</td>
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<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
</tr>
<tr>
<td>NPSA</td>
<td>National Patient Safety Agency</td>
</tr>
<tr>
<td>NPV</td>
<td>Negative Predictive Value</td>
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<td>NRT</td>
<td>Nicotine Replacement Therapy</td>
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<td>NSAIDs</td>
<td>Non-Steroidal Anti-Inflammatory Drugs</td>
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<td>NSF</td>
<td>National Service Framework</td>
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<tr>
<td>OB</td>
<td>Obesity</td>
</tr>
<tr>
<td>OGTT</td>
<td>Oral Glucose Tolerance Test</td>
</tr>
<tr>
<td>ONS</td>
<td>Office for National Statistics</td>
</tr>
<tr>
<td>OST</td>
<td>Osteoporosis</td>
</tr>
<tr>
<td>OTC</td>
<td>Over The Counter</td>
</tr>
<tr>
<td>PAD</td>
<td>Peripheral Arterial Disease</td>
</tr>
<tr>
<td>PC</td>
<td>Palliative Care</td>
</tr>
<tr>
<td>PCR</td>
<td>Protein:Creatinine Ratio</td>
</tr>
<tr>
<td>PE</td>
<td>Patient Experience</td>
</tr>
<tr>
<td>PEF</td>
<td>Peak Expiratory Flow</td>
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<tr>
<td>PHQ-9</td>
<td>Nine Item Patient Health Questionnaire</td>
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<td>PCRJ</td>
<td>Primary Care Respiratory Journal</td>
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<td>PVD</td>
<td>Peripheral Vascular Disease</td>
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<td>QMAS</td>
<td>Quality Management and Analysis System</td>
</tr>
<tr>
<td>QOF</td>
<td>Quality and Outcomes Framework</td>
</tr>
<tr>
<td>QP</td>
<td>Quality and Productivity</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>RA</td>
<td>Rheumatoid Arthritis</td>
</tr>
<tr>
<td>RCGP</td>
<td>Royal College of General Practitioners</td>
</tr>
<tr>
<td>RCP</td>
<td>Royal College of Physicians</td>
</tr>
<tr>
<td>RCN</td>
<td>Royal College of Nurses</td>
</tr>
<tr>
<td>RCTs</td>
<td>Randomised Controlled Trials</td>
</tr>
<tr>
<td>SCR</td>
<td>Supportive Care Register</td>
</tr>
<tr>
<td>SIGN</td>
<td>Scottish Intercollegiate Guidelines Network</td>
</tr>
<tr>
<td>SMOK</td>
<td>Smoking</td>
</tr>
<tr>
<td>SSRI</td>
<td>Selective Serotonin Reuptake Inhibitors</td>
</tr>
<tr>
<td>STIA</td>
<td>Stroke or Transient Ischemic Attack</td>
</tr>
<tr>
<td>TIA</td>
<td>Transient Ischemic Attack</td>
</tr>
<tr>
<td>THY</td>
<td>Thyroid</td>
</tr>
<tr>
<td>TPCR</td>
<td>Total Protein: Creatinine Ratio</td>
</tr>
<tr>
<td>TSH</td>
<td>Thyroid Stimulating Hormone</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
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<tr>
<td>WG</td>
<td>Welsh Government</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
</tbody>
</table>
Annex 1

Cluster Network Development Domain

Local Health Board Support and Engagement

Introduction

The delivery of local health services and more care in the community is a key element of LHB’s 3 year service delivery plans.

*A Plan for a Primary Care Service for Wales* sets out a vision for the development of primary care services to March 2018. The aim is to develop a more ‘social’ model of health which promotes physical, mental and social wellbeing, rather than just the absence of ill health. This approach, which draws in all the relevant public and voluntary sector services to support individuals, recognises the skills and resources patients themselves bring to achieving the outcomes that matter most to them.

The role of GP practices

GP practices play a central role in the delivery of local healthcare and will increasingly work with other partners to maximise the potential of local resources and expertise.

In particular, GP practices will engage in the cluster network agenda to develop and deliver actions agreed in the cluster network action plan. The minimum requirement will be one GP and practice manager / senior administrative employee per meeting. Single handed and small practices [2 or 3 partners] may discuss with the cluster network members and Health Board representatives the appropriateness of “buddying” arrangements to ensure the engagement of small practices and to minimise disruption to service delivery.

The cluster network development domain for 2015/16 seeks to strengthen GP multi-disciplinary team working through facilitating opportunities to meet with other health professionals twice during the year. The RCGP “A Vision for General Practice in the future NHS : The 2022 GP “ highlights the future GP will provide continuity of care to patients with a range of complex needs, especially those with long-term conditions and those near the start and end of life. The structures through which this care will be provided will need to be tailored by practices and practitioners, in response to local circumstances. Models could include the development of small multidisciplinary units made up of a range of professionals with different skills, such as the GP, nurse, healthcare assistant, social care worker and patient advocate, attached to practices and providing continuity to an identified group of patients. Micro-teams could also include practitioners from other specialties, such as mental health, paediatrics and medicine. These ‘micro-teams’ will provide extended clinical reviews and support, enabling greater shared decision-making with patients and carers, as well as improved continuity of care.

This work is important to meet patients needs but also to address current workforce recruitment and retention concerns. This approach allows GP teams to play a central
role in designing more connected local services whilst retaining personalised, holistic care.

Practices should identify key issues from their own practice development plans to discuss at cluster network meetings to identify common themes that might be addressed through agreed actions.

The role of GP clusters

Cluster networks will be supported by LHBs to develop increasing autonomy and greater influence over local service improvement and delivery as they mature.

Cluster networks will also increasingly manage local resources to allow greater flexibility and more rapid local decision making. This will require robust governance and accountability frameworks together with engagement and confidence from the clusters and their partners.

The cluster network development domain seeks to:
- Enable individual practices to proactively plan their services to meet local needs and ensure sustainability
- Strengthen the primary healthcare team around local clusters of GP practices to improve communication and coordination of services
- Ensure services are developed to meet the needs of the local population.
- Develop professional networks and partnership working—specifically: public health; secondary care (co-opted where needed); pharmacy (community and LHB employed); voluntary sector; local authority and social care.
- To identify the areas which will have the biggest impact on improving healthcare, utilising a range of external resources such as:
  - Observatory resources such as the GP Cluster Profiles
  - QOF comparators of achievement
  - National Audit and Clinical Outcome Review findings
  - Welsh Government policy and strategy
  - PCQUIS products; 1000 Lives Plus
  - Audit + data
- Develop a clear primary care quality improvement agenda.
- Improve patient access to services by developing collaborative working including cross referrals between practices and mapping where services are available.
- Develop more effective skill mix across practices and the community
- Reinvigorate the primary and secondary care relationship
- Mature strategies that are built around the whole patient pathway from health promotion and prevention onwards into secondary / tertiary care.
- Address key priorities for Wales which for Year 2 are:
  - Early detection of cancer (specifically, gastrointestinal and lung and ovarian)
  - Consistent, high quality end of life care Minimising the harms of polypharmacy
To engage in the development of local workforce and CPD strategies that ensure sustainable delivery of primary and community care and support new service delivery models

The second year of the Cluster Network Development Programme (2015-16) builds on the progress made in 2014/15 to:

- Ensure the sustainability of core services with appropriate risk management and actions to address local needs, including improved access to services.
- Strengthen GP multi-disciplinary team working and inform local workforce strategies.
- Further develop horizontal integration to support sustainable general practice and new models of care led by local teams (for example, developments may include cross referral for clinical care; federations of GP practices; shared administrative support; full practice mergers).
- Further develop local needs assessment working closely with colleagues in public health and developing a shared understanding of priorities across health and social care services.
- Develop more effective collaborative working with community services (including nursing, local authority and third sector) to improve the coordination and quality of care and to optimise the availability of professional skills. Prioritise signposting to the most appropriate professional or self care.
- Further develop 2014/15 cluster network actions where appropriate.

The role of Local Health Boards

Local Health Boards will:

- Provide proactive support to each GP cluster network through identified clinical and managerial leads.
- Work with cluster representatives to enable single handed and small practices (2 or 3 partners) to engage fully either through having GP / Practice Manager attending or enabling "buddying" of a small practice with a larger practice and thus reducing attendance at each meeting. If "buddying" is implemented there will be an expectation the small practice will still engage in the full work of the cluster through email participation / directly feeding in comments etc to the "buddy" practice.
- Provide appropriate and timely information to support needs assessment and service improvement plans
- Facilitate appropriate links to enable GP cluster network development (e.g. secondary care consultants engaging in cluster work in high impact areas or when discussing referral data, public health).
- Ensure that GP cluster network meetings are effective and efficient, with agreed actions and regular review of progress
- Expand the delivery of community based services to support the delivery of care closer to home
- Ensure that opportunities and constraints to progress are recognised and inform local and national action
- Through active support of this agenda, address health inequalities and enable more integrated health and social care at a GP cluster network level.
• Have appropriate local systems in place to manage local resources, including work over and above contractual requirements.

Specific Local Health Board support in relation to Cluster Network Development

LHB’s are required to identify the LHB network lead or nominated person to support contractors. It is expected the designated person will be at an appropriate level of seniority to engage proactively in decision making.

CND001W: Practice Development Plan.

• The LHB network lead or nominated person will support contractors by providing relevant information and responding to requests for data. The LHB network lead or nominated person and Local Public Health Teams will be important contacts. The LHB network lead or nominated person will work with the Public Health Team to facilitate access to relevant data (for example, planned referral data; admission/emergency attendance data; disease prevalence) to inform the review of the practice profile.

• In relation to the full PDP to be shared with the LHB (by 30 June 2015), the LHB network lead or nominated person will agree with the practice any information which may need to be redacted (for example, any information deemed “commercially in confidence”). These discussions should take place with the practice as soon as possible.

• In relation to PDP objectives and priorities to be published on My Local Health Service (by 30 September 2015), LHBs will agree with the practice the information (at page 22/25 Annex 2) to be published. These discussions should take place with the practice as soon as possible after having received the PDP and information published as soon as possible after 30 September 2015.


• The LHB network lead or nominated person will collate and ensure the Cluster Network Action Plan is completed.

• Key themes and issues from Practice Development Plans should be discussed at GP cluster network meetings.

• The LHB network lead or nominated person will co-ordinate cluster network meetings.

• The LHB network lead or nominated person will facilitate the cluster network meetings and will ensure that the agreed prioritised actions identified in the Cluster Network Action Plan are consistent with the LHB’s strategic objectives. If there is clear non alignment of local needs with LHB strategic objectives, the LHB lead will facilitate further discussion with the GP practice.

• The LHB network lead or nominated person should proactively respond before the GP cluster network meeting to any issues raised by contractors.

• The LHB network lead or nominated person will work with single handed and small practices (2 or 3 partners) to enable them to engage fully either through
having GP / Practice Manager attending or enabling “buddying” of a small practice with a larger practice and thus reducing attendance at each meeting. If “buddying” is implemented there will be an expectation the small practice will still engage in the full work of the cluster through email participation / directly feeding in comments etc. to the “buddy” practice.

- The LHB network lead or nominated person will facilitate a cluster network meeting with the LHB community networks and other service users at least once during the year to improve the coordination and quality of care, access to wider community assets and responding to service user needs. This cluster network meeting with the LHB community networks and other service users include for example, LHB Neighbourhood Care Networks; LHB Community Networks; LHB Locality Networks. The LHB network lead or nominated person will also be expected to facilitate this meeting.

In relation to the cluster network action plan to be published on My Local Health Service (by 31 December 2015), LHBs will agree with the cluster network the information to be published. These discussions should take place with the Cluster as soon as possible after having received the cluster network action plan and information published as soon as possible after 30 September 2015.

CND003W: Implementation and delivery of the Cluster Network Action Plan

- The LHB network lead or nominated person will facilitate each GP cluster network meeting

CND 004W: Cluster Network Annual Report

- In relation to the cluster network annual report to be published on My Local Health Service (by 30 June 2015), LHBs will agree with the cluster network the information to be published. These discussions should take place with the Cluster as soon as possible after having received the cluster network action plan and information published as soon as possible after 30 June 2015.

Other issues to be considered by the Local Health Board

The LHB should consider the extent to which the prioritised actions outlined in the Cluster Network Action Plan address local health priorities and are aligned with the LHB’s three year strategic plans

The LHB should consider, in partnership with the GP cluster network, the capacity for contractors to deliver the actions identified for inclusion in the Cluster Network Action Plan

As indicated at CND 002W, the cluster network action plan will address the following key areas:

- Access arrangements - comparison of core access arrangements; exploration of adjuvants to access (including telephone arrangements); user experience; consider Welsh Language provision and the other language needs of the practice; the impact of My Health On Line where it is available to practices; responding to urgent requests and same day requests from care homes, Welsh Ambulance Services and hospital emergency departments.
Consideration of how resources can be used most effectively to provide local access to services
  o to which patients require frequent access (such as phlebotomy, including anticoagulation management, ECG, spirometry)
  o support effective self management, including management of minor illness,
  o support the more effective management of chronic conditions (such as structured diabetes education, cardiac and pulmonary rehabilitation).

These discussions will include the extent to which new resources may be required to deliver improved local services to patients and included in the cluster network action plan.

- Mapping of local GP services to highlight where services are delivered across practices (for example, contraceptive services, minor surgery)
- Particular reference to access for vulnerable groups (including asylum seekers, homeless, and patients with learning disabilities).
- Consideration of how new approaches to the delivery of primary care might aid service delivery and ensure sustainability of local services. Developments might include new technologies, development of clinical roles, further development of cross referral and increased skill mix.
- Consideration of the impact of local care pathway work relating to previous QOF work,
- Actions to foster greater integration of health and social care.
- Consideration of how third sector support may be maximised

LHB’s will need to consider the extent to which increased resources are made available to GP cluster networks given the requirements of CND 002W.

LHB’s will also need to consider the support it can offer to GP cluster networks to maximise community resources to meet local needs through the more effective use of local resources and actions to foster greater integration of health and social care.
QOF Indicator CND 001W supports the GP contractor to undertake a review of local need and the provision of services by the practice and to create a Practice Development Plan with priorities for action. The Practice Development Plan will inform discussions at GP Cluster meetings.
The contractor should ensure that patient views are considered and that where possible, patients have the opportunity to contribute to the development of priorities through a patient participation group or other formal / informal feedback processes.

This template is provided to ensure that Contractors fulfil the requirements of the CND1 indicator and should be completed and shared with the Health Board by 30 June 2015.

The practice retains ownership of the document. The practice development plan at page 22/25 is the section the practice will use for cluster discussions.

Suggestions for improvement of the document and this process must be shared with the LHB to ensure that this process drives the improvement of contractor services, ensures sustainability, informs the development of appropriate educational support and influences the redesign of services to more effectively address local needs.

Please Type the report:

All sections should be completed, please use “not applicable” where appropriate

Complete all the yellow shaded boxes - these will expand to fit entered text

<table>
<thead>
<tr>
<th>Our population: Demography</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice List size</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practice List Size:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this increasing, decreasing or static?</td>
</tr>
<tr>
<td>How does this compare with local and national data and trends?</td>
</tr>
<tr>
<td>Consider the implications for workforce plans</td>
</tr>
</tbody>
</table>

Commentary (e.g. new housing developments)
### Particular population features

Indicate all population groups where particular service needs may apply such as high numbers of students; asylum seekers; rural isolation; Welsh language and other languages specific to the practice, high care home population; high mental health population etc.

This may be important for identifying opportunities for collaboration with other practices, community teams or voluntary sector organisations.

### Social Factors:

Consider any particular social factors that are relevant to your population, such as deprivations, unemployment, housing issues etc.

Consider partners who might provide advice and support for particular needs.
Disease Prevalence:

Compare patterns of disease with other local practices and identify variations.

Consider information from Public Health Wales in relation to prevalence of particular patterns of disease for your practice population and compare with the practice recorded prevalence patterns to ensure that case finding approaches are effective.

Consider local and national comparative data

Where recorded prevalence patterns are higher than prevalence patterns identified by Public Health Wales consider the potential for the development of practice or locality based support services

Practice Population Needs Assessment

<p>| Key Health Priorities Identified by Practice |</p>
<table>
<thead>
<tr>
<th><strong>Key health priorities identified from external sources</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Access issues (refer to information on 5As and “sort it in one call” policy, as an example of good practice)</td>
</tr>
<tr>
<td>Unscheduled care / admissions issues</td>
</tr>
<tr>
<td>Any ongoing issues from previous QOF QP work:</td>
</tr>
<tr>
<td>Planned referral/admission data- variation.</td>
</tr>
<tr>
<td>Accident and emergency admissions</td>
</tr>
<tr>
<td>Prescribing</td>
</tr>
<tr>
<td>Key issues arising from complaints/suggestions and any formal investigations #</td>
</tr>
<tr>
<td>Key issues arising from Significant Event Analyses</td>
</tr>
<tr>
<td>Key issues arising from Practice Visits (LHB/CHC)</td>
</tr>
<tr>
<td>Key issues arising from practice profile (access, services, training etc)</td>
</tr>
<tr>
<td><strong>Summary of agreed key issues and priorities arising from the above categories</strong></td>
</tr>
</tbody>
</table>
Consider relevant documents such as Health Board plans, Welsh Government strategies e.g. Together for Health, NICE guidance

#Such as Ombudsman reports, Health Board investigations (*where relevant*)

**Service provision**

Having considered the needs of the population, the practice should summarise the current provision of services.

Development objectives should relate to the agreed priorities arising from the needs assessment.

Practices should consider issues in three areas: -

- Practice developments
- Priorities for action at the GP Cluster level
- System issues for consideration by the Local Health Board

At each level, consideration should be given to the potential for collaborative working to maximise the potential of community resources.

<table>
<thead>
<tr>
<th><strong>Access arrangements</strong></th>
</tr>
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<tbody>
<tr>
<td><strong>Opening Hours</strong></td>
</tr>
<tr>
<td><strong>Reception opens at:</strong></td>
</tr>
<tr>
<td><strong>Reception closes at:</strong></td>
</tr>
<tr>
<td><strong>Half-day closure: yes/no:</strong></td>
</tr>
<tr>
<td><strong>Lunchtime Closure yes/no:</strong></td>
</tr>
<tr>
<td><strong>Telephone to reception available 8am until 630pm: yes/no</strong></td>
</tr>
<tr>
<td><strong>Comments:</strong></td>
</tr>
<tr>
<td><strong>Appointments</strong></td>
</tr>
</tbody>
</table>
**Time of 1st bookable appointment:** <            >

*Appointments routinely available*

After 5pm yes/no
After 530pm yes/no
After 6pm yes/no

**Same Day Access**

Summarise the process for urgent/same day requests for consultations such as telephone advice, open access surgeries

**Care Homes**

Consider the population served.

Is an enhanced service arrangement available? If so, does the practice participate?

Consider the process for responding to requests for urgent assessment.
Support to A&E and Ambulance Services

Consider the processes in place in the practice for providing support to A&E or Ambulance services who are requesting urgent advice or a consultation in respect of your patients:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access Analysis</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Consultation Rates</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Summarise the consultation rates as set out below, describing the numbers as rate/1000 registered patients per week</strong></td>
<td></td>
</tr>
<tr>
<td>Pre-bookable GP appointments with GP:</td>
<td>(   ) per 1000 patients</td>
</tr>
<tr>
<td>Open-access consultations with GP:</td>
<td>(   ) per 1000 patients</td>
</tr>
<tr>
<td>Pre-bookable GP appointments with Nurse/HCA:</td>
<td>(   ) per 1000 patients</td>
</tr>
<tr>
<td>Open-access consultations with Nurse/HCA:</td>
<td>(   ) per 1000 patients</td>
</tr>
<tr>
<td><strong>Telephone Consultations:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Estimated number of telephone consultation per week:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Summarise any special arrangements for telephone consultations (for</strong></td>
<td></td>
</tr>
</tbody>
</table>
example, pre bookable telephone consultations) :

<table>
<thead>
<tr>
<th>Home Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimate the number of home visits per week: ( ) per 1000 registered patients</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Typical Waits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider the typical wait for an appointment booked in advance with Any GP?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Did Not Attends</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated DNA rate (°)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other issues affecting access</th>
</tr>
</thead>
<tbody>
<tr>
<td>The team should reflect on the balance of capacity and demand and consider how services might be developed. Practices should consider:</td>
</tr>
<tr>
<td>- Examples of good practice such as from discussions with peers/ articles read / experience of systems in use in other practices</td>
</tr>
<tr>
<td>- Learning from discussions at cluster meetings</td>
</tr>
<tr>
<td>- Use of patient feedback to identify opportunities to improve practice systems</td>
</tr>
<tr>
<td>- Opportunities to maximise the potential of the whole team</td>
</tr>
<tr>
<td>- Identify barriers to the delivery of access to meet local needs</td>
</tr>
</tbody>
</table>

Where appropriate the Practice Development plan should identify any objectives for improvement and measures to monitor progress

<table>
<thead>
<tr>
<th>Service Provision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Services¹¹⁵</td>
</tr>
</tbody>
</table>

¹¹⁵ Additional services are identified at Part 1 (2) NHS (General Medical Services Contracts) (Wales) Regulations 2004
**Indicate which of the additional services are provided:**

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical Cytology</td>
<td></td>
</tr>
<tr>
<td>Contraception</td>
<td></td>
</tr>
<tr>
<td>Vaccinations and Immunisations (excluding childhood programme)</td>
<td></td>
</tr>
<tr>
<td>Childhood Immunisations</td>
<td></td>
</tr>
<tr>
<td>Minor Surgery (Curettage &amp; Cautery)</td>
<td></td>
</tr>
<tr>
<td>Child Health Surveillance</td>
<td></td>
</tr>
<tr>
<td>Maternity Services</td>
<td></td>
</tr>
</tbody>
</table>

**Enhanced Services**

**Indicate which of the following enhanced services are provided:**

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extended Hours</td>
<td></td>
</tr>
<tr>
<td>Minor Surgery (excisions &amp; injections)</td>
<td></td>
</tr>
<tr>
<td>Near Patient Testing (please indicate which level)</td>
<td></td>
</tr>
<tr>
<td>IUCD/IUS</td>
<td></td>
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<tr>
<td>Depo-provera</td>
<td></td>
</tr>
<tr>
<td>Contraceptive Implants</td>
<td></td>
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<tr>
<td>Anticoagulation (indicate which level)</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>Care Homes</td>
<td></td>
</tr>
<tr>
<td>Asylum Seekers</td>
<td></td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td></td>
</tr>
<tr>
<td>Homelessness</td>
<td></td>
</tr>
</tbody>
</table>
Childhood Immunisation target payments: Yes/No
Substance Misuse: Yes/No
Services to violent patients: Yes/No
Immunisation: Yes/No
Mental Health: Yes/No

Others:

Review and actions:

Practices should consider any gaps or duplications and will also wish to consider the potential for collaborative arrangements across cluster areas.

Dispensing

Does the practice provide dispensing services: Yes/No

Number of dispensing patients:

Dispensing Quality Scheme (Yes/No)

Comments:
### Education & Training

<table>
<thead>
<tr>
<th>Question</th>
<th>ST1</th>
<th>ST2</th>
<th>ST3</th>
<th>ST4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the practice recognised for GP training?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Placements offered ST2 Yes/No ST3 Yes/No ST4 Yes/No</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Does the practice offer returner placements : Yes/No</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the practice offer retainer placements : Yes/No</td>
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<td></td>
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<tr>
<td>Is the practice an advanced training practice: Yes/No</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Comments (Including any plans to change provision):</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the practice provide educational supervision to GP registrars in hospital placements? Yes/No</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ST1 Yes/No ST2 Yes/No</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the practice provide placements to Foundation Doctors Yes/No</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the practice provide placements to medical students from:</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Cardiff University Yes/No</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swansea University Yes/No</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other medical schools Yes/No</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Nurse Training
<table>
<thead>
<tr>
<th>Questions</th>
<th>Yes/No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the practice provide educational placements for nurses at undergraduate or postgraduate level?</td>
<td>Yes/No</td>
<td></td>
</tr>
<tr>
<td>Other training:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the practice provide training to other professionals</td>
<td>Yes/No</td>
<td></td>
</tr>
<tr>
<td>Other Roles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GPWSI (please indicate area of special interest)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appraisal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Leadership(^{116})</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^{116}\) Clinical Leadership includes educational leadership, political leadership, managerial leadership and GP cluster leadership.
### Research

Other

**Contractors should consider development priorities and actions**

### Data Collection

<table>
<thead>
<tr>
<th></th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the practice permit Data extraction by <em>Audit Plus</em></td>
<td></td>
</tr>
<tr>
<td>Does the practice permit Data extraction by <em>SAIL</em></td>
<td></td>
</tr>
</tbody>
</table>

If not, reasons for non-participation

---

117 GPC Wales supports the extraction of data from Audit Plus and SAIL and participates in the data governance approval process. There is a Focus on Welsh IM&T document available on the BMA website for practices wanting information / assurance around data governance of Audit +, SAIL, IHR.
## Private Services

Consider any private services provided to registered and non-registered patients by the practice e.g. occupational health, travel vaccines (non-GMS)

This information may be relevant to the practice Development Plan.
## Workforce

### Current Practice Workforce

<table>
<thead>
<tr>
<th>Role (name)</th>
<th>Name</th>
<th>Working Arrangements</th>
<th>Number of Clinical Sessions Worked in the practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor: Partners</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor: Salaried</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor: Retainers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor: Returners</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor: Trainees</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice Manager</td>
<td></td>
<td>Partner/Employee (indicate which)</td>
<td>Hours Worked</td>
</tr>
<tr>
<td>Practice Nurse: Practitioners</td>
<td></td>
<td></td>
<td>Hours Worked</td>
</tr>
</tbody>
</table>
### Practice Nurse

<table>
<thead>
<tr>
<th>Roles/Tasks</th>
<th>Wound Care (Y/N)</th>
<th>Respiratory Clinic (Y/N)</th>
<th>Cardiovascular (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Clinic</td>
<td>(Y/N)</td>
<td>Wound Care (Y/N)</td>
<td>Child Immunisation (Y/N)</td>
</tr>
<tr>
<td></td>
<td>ECG (Y/N)</td>
<td>Contraception (Y/N)</td>
<td>Minor Ailments (Y/N)</td>
</tr>
</tbody>
</table>

**Comments:** e.g. any plans to reduce / increase staffing or change current staff mix because of funding concerns

Practices should consider short, medium and long term plans for their workforce

---

### Workforce (continued)

<table>
<thead>
<tr>
<th>HCSW</th>
<th>Total Hours worked:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Roles</th>
<th>Phlebotomy (Y/N)</th>
<th>ECG (Y/N)</th>
<th>Spirometry (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP monitoring (Y/N)</td>
<td>Injections (Y/N)</td>
<td>Wound Care</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<p>| Other employed staff| (e.g. counsellors, |     |                |
|---------------------|---------------------|     |                |</p>
<table>
<thead>
<tr>
<th>Predictions on workforce</th>
<th>Changes in Next 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Changes in next three years</td>
</tr>
</tbody>
</table>

**Other workforce concerns e.g. recruitment difficulties:**

**Partnership working**

Contractors should consider key contacts and the potential for provision of services within the practice or through local network arrangements, such as:

- District Nurses
- Health visitors
- Phlebotomists
- Counsellors
- Voluntary sector
- Communities First
<table>
<thead>
<tr>
<th><strong>Premises</strong>*</th>
<th><strong>Main Surgery</strong></th>
<th><strong>Branch Surgery</strong></th>
<th><strong>Concerns Regarding premises</strong></th>
<th><strong>Other agencies using premises</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Purpose-Built (Y/N)</td>
<td>Adapted (Y/N)</td>
<td>Health Centre (Y/N)</td>
<td>Shared Building (Y/N)</td>
</tr>
<tr>
<td></td>
<td>Practice Owned (Y/N)</td>
<td>Health Board Owned (Y/N)</td>
<td>Privately Owned (Y/N)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No of consulting Rooms</td>
<td>No of Treatment Rooms</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Purpose-Built (Y/N)</td>
<td>Adapted (Y/N)</td>
<td>Health Centre (Y/N)</td>
<td>Shared Building (Y/N)</td>
</tr>
<tr>
<td></td>
<td>Practice Owned (Y/N)</td>
<td>Health Board Owned (Y/N)</td>
<td>Privately Owned (Y/N)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No of consulting Rooms</td>
<td>No of Treatment Rooms</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Space (Y/N)</td>
<td>Disability Access (Y/N)</td>
<td>State of Repair (Y/N)</td>
<td>Suitable consulting spaces (Y/N)</td>
</tr>
<tr>
<td></td>
<td>Clinic Room Facilities (Y/N)</td>
<td>Waiting Room (Y/N)</td>
<td>Office Space (Y/N)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other concerns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Carer Support (Y/N)</td>
<td>Counselling (Y/N)</td>
<td>Benefits Advice (Y/N)</td>
<td>Employment support (Y/N)</td>
</tr>
<tr>
<td></td>
<td>Others:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other comments on premises;</td>
<td>E.g. requested or put in bid for improvement grant / need new premises etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Completeness of this section depends on practice need. As a result there could be additional sections or some sections are not appropriate.
## Services

<table>
<thead>
<tr>
<th>Priority</th>
<th>The issues</th>
<th>Aims and objectives</th>
<th>How will this be done? (Practice; GP Cluster; Health Board)</th>
<th>Named Lead</th>
<th>Time Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Planned Care:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral</td>
<td></td>
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<tr>
<td>management</td>
<td></td>
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<tr>
<td>and care</td>
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<tr>
<td>pathways</td>
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<tr>
<td>Unscheduled</td>
<td></td>
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<tr>
<td>care</td>
<td></td>
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<tr>
<td>Practice Developments</td>
<td>End of life care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td></td>
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<tr>
<td>e.g. New clinical services</td>
<td>National Clinical priorities</td>
<td></td>
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</tr>
<tr>
<td>Teaching and training</td>
<td>Cancers</td>
<td></td>
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<td></td>
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<tr>
<td>Collaborative arrangements</td>
<td>Frailty and polypharmacy</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

## Workforce Plan

<table>
<thead>
<tr>
<th>Issue</th>
<th>Background</th>
<th>What will be done?</th>
<th>How will this be done? (Practice; GP Cluster; Health Board)</th>
<th>Named Lead</th>
<th>Time Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>


### Premises Plan

<table>
<thead>
<tr>
<th>Issue</th>
<th>Why?</th>
<th>What will be done?</th>
<th>How will this be done? (Practice; GP Cluster; Health Board)</th>
<th>Named Lead</th>
<th>Time Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cluster Network issues</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>LHB Issues</td>
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</table>
Annex 3

Cluster Network Action Plan 2015-16

xxxxxxxxxxx Cluster
The Cluster Network Development Domain supports GP Practices to work to collaborate to:

- Understand local health needs and priorities.
- Develop an agreed Cluster Network Action Plan linked to elements of the individual Practice Development Plans.
- Work with partners to improve the coordination of care and the integration of health and social care.
- Work with local communities and networks to reduce health inequalities.

The Cluster Network Action Plan should be a simple, dynamic document.

The Cluster Network Action Plan should include:

- Objectives that can be delivered independently by the network to improve patient care and to ensure the sustainability and modernisation of services.
- Objectives for delivery through partnership working
- Issues for discussion with the Health Board

For each objective there should be specific, measurable actions with a clear timescale for delivery.

Cluster Action Plans should compliment individual Practice Development Plans, tackling issues that cannot be managed at an individual practice level or challenges that can be more effectively and efficiently delivered through collaborative action. This approach should support greater consistency of service provision and improved quality of care, whilst more effectively managing the impact of increasing demand set against financial and workforce challenges.

The action plan may be grouped according to a number of strategic aims.

**Strategic Aim 1: To understand the needs of the population served by the Cluster Network**

<table>
<thead>
<tr>
<th>No</th>
<th>Objective</th>
<th>Key partners</th>
<th>For completion by: -</th>
<th>Outcome for patients</th>
<th>Progress to date</th>
<th>RAG Rating</th>
</tr>
</thead>
</table>

**Strategic Aim 2: To ensure the sustainability of core GP services and access arrangements that meet the reasonable needs of local patients**

118 A GP cluster network is defined as a cluster or group of GP practices within the Local Health Board’s area of operation as previously designated for QOF QP purposes
<table>
<thead>
<tr>
<th>No</th>
<th>Objective</th>
<th>Key partners</th>
<th>For completion by: -</th>
<th>Outcome for patients</th>
<th>Progress to Date</th>
<th>RAG Rating</th>
</tr>
</thead>
</table>

Strategic Aim 3: Planned Care- to ensure that patients needs are met through prudent care pathways, facilitating rapid, accurate diagnosis and management and minimising waste and harms

<table>
<thead>
<tr>
<th>No</th>
<th>Objective</th>
<th>Key partners</th>
<th>For completion by: -</th>
<th>Outcome for patients</th>
<th>Progress to Date</th>
<th>RAG Rating</th>
</tr>
</thead>
</table>

Strategic Aim 4: To provide high quality, consistent care for patients presenting with urgent care needs and to support the continuous development of services to improve patient experience, coordination of care and the effectiveness of risk management

<table>
<thead>
<tr>
<th>No</th>
<th>Objective</th>
<th>Key partners</th>
<th>For completion by: -</th>
<th>Outcome for patients</th>
<th>Progress to Date</th>
<th>RAG Rating</th>
</tr>
</thead>
</table>

Strategic Aim 5: Improving the delivery of end of life care

<table>
<thead>
<tr>
<th>No</th>
<th>Objective</th>
<th>Key partners</th>
<th>For completion by: -</th>
<th>Outcome for patients</th>
<th>Progress to Date</th>
<th>RAG Rating</th>
</tr>
</thead>
</table>

Strategic Aim 6: Targeting the prevention and early detection of cancers

<table>
<thead>
<tr>
<th>No</th>
<th>Objective</th>
<th>Key partners</th>
<th>For completion by: -</th>
<th>Outcome for patients</th>
<th>Progress to Date</th>
<th>RAG Rating</th>
</tr>
</thead>
</table>
### Strategic Aim 7: Minimising the risk of poly-pharmacy

<table>
<thead>
<tr>
<th>No</th>
<th>Objective</th>
<th>Key partners</th>
<th>For completion by: -</th>
<th>Outcome for patients</th>
<th>Progress to Date</th>
<th>RAG Rating</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

### Strategic Aim 8: Deliver consistent, effective systems of Clinical Governance

<table>
<thead>
<tr>
<th>No</th>
<th>Objective</th>
<th>Key partners</th>
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<th>Outcome for patients</th>
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<th>RAG Rating</th>
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</table>

### Strategic Aim 9: Other Locality issues

<table>
<thead>
<tr>
<th>No</th>
<th>Objective</th>
<th>Key partners</th>
<th>For completion by: -</th>
<th>Outcome for patients</th>
<th>Progress to Date</th>
<th>RAG Rating</th>
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</table>
Cluster Network Annual Report

Introduction

The guidance includes GP practice summary schedules for the general practice national priority areas - early diagnosis of cancer; end of life care; frailty and polypharmacy. The annual report should identify what has been learned and any actions taken.

Contents

Annex 4 comprises:

- A format for the GP Network Annual Report which includes the following areas: review of the needs of the community; agreed priorities for 2015/16; achievements for 2015/16; plans for 2016/17.

- A Risk Register. Clusters are encouraged to identify any difficulties. The areas highlighted include diabetes structured education; pulmonary rehabilitation; cardiac rehabilitation, but other risks may also need to be highlighted.

Annex 6a, 7a and 8a can provide the basis to inform the annual report in relation to national priority areas – cancer; end of life; and polypharmacy.
### XXXXX GP Cluster Network Annual Report 2015/16

**Our network:**
- We are a xx practices with yy main and zz branch surgeries.
- Xx practices are engaged in training/ research

**Our community:**
- We serve a population of xxxx in a rural/urban environment. The particular features of our population are ..........

<table>
<thead>
<tr>
<th>We looked at the needs of our community : -</th>
<th>Our agreed priorities for 2015/16 were:-</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Xx</td>
<td>• Xx</td>
</tr>
<tr>
<td>• Xx</td>
<td>• Xx</td>
</tr>
<tr>
<td>• Xx</td>
<td>• X</td>
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<tr>
<td>• Xx</td>
<td>• Xx</td>
</tr>
<tr>
<td>• xx</td>
<td>• Xx</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What we have achieved : -</th>
<th>Our plans for2016/17 :-</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Xx</td>
<td>• Xx</td>
</tr>
<tr>
<td>• Xx</td>
<td>• Xx</td>
</tr>
<tr>
<td>• Xx</td>
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<td>• Xx</td>
<td>• Xx</td>
</tr>
<tr>
<td>• xx</td>
<td>• xx</td>
</tr>
<tr>
<td>Service</td>
<td>Rationale</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>----------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Access to exercise-based rehabilitation | For patients with heart failure exercise –based rehabilitation can have a significant impact on quality of life and reduce demand on health services  
• Patients who have been newly diagnosed as suffering with heart failure to an exercise-based rehabilitation programme. | Xx practices do not have access to this service  
The estimated unmet need is xx patients |                                                                        |
| Access to pulmonary rehabilitation | Pulmonary rehabilitation is an evidence based intervention that has been shown to improve quality of life and reduce demand on health services  
As part of the GMS contract General Practitioners are expected to refer:  
• Patients who have COPD and have Medical Research Council dyspnoea which is grade three or above to a pulmonary rehabilitation programme. | Xx practices do not have access to this service  
The estimated unmet need is xx patients |                                                                        |
| Access to structured diabetes education | Structured diabetes education is an evidence based intervention that supports patient self management | Xx practices do not have access to this service  
The estimated unmet need is xx patients |                                                                        |
As part of the GMS contract General Practitioners are expected to refer:

- Patients who have been newly diagnosed as suffering with diabetes to a structured diabetic education programme.
GP Cluster Network Development Domain

The Clinical Governance Practice Self Assessment Toolkit

Clinical governance is defined as “a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish” 119

The GP contract requires ‘the contractor shall have an effective system of clinical governance...The system of clinical governance means a framework through which the contractor endeavors continuously to improve the quality of its services and safeguard high standards of care by creating an environment in which clinical excellence can flourish’ 120

The Clinical Governance Practice Self Assessment Tool (CGPSAT) supports practices to undertake a systematic, comprehensive review of practice systems to ensure that all contractual and statutory obligations are satisfied. The toolkit follows a maturity matrix approach, enabling practices to identify areas for improvement and to include actions in an holistic practice development plan.

The introduction of a QOF indicator to support the use of the CGPSAT should ensure high levels of participation across Wales. This consistent approach will allow peer review, shared learning and common development through GP Cluster Action Plans, where appropriate.

The Public Health Wales website is currently being updated to include new versions of all CGPSAT background information and to support GP practices and Health Boards http://howis.wales.nhs.uk/sitesplus/888/CGPSAT

Requirements

CND 005W. The contractor updates the Clinical Governance Practice Self Assessment Toolkit 121 (CGPSAT) and to confirm completion and submission to the LHB by 31 March 2016.

The contractor participates in a review of the appropriate healthcare standards in relation to the promotion of safeguarding vulnerable adults; adults with a learning disability; safeguarding children. Practices are expected to achieve at least level 2 CGPSAT assurance. Any improvement actions to be identified by 31 March 2016, or actioned during the year if early identification allows.

120 Part 9 (119 ) NHS ( General Medical Services Contracts ) ( Wales ) Regulations 2004
121 http://www.wales.nhs.uk/sitesplus/888/page/44038
When completing the CGPSAT, practices may identify areas for development. Key strengths and needs or constraints can be noted in each section and these will be amalgamated to produce a single document which can be saved and/or printed for inclusion in the practice’s development plan. The CGPSAT tutorial gives instructions for generating this report http://howis.wales.nhs.uk/sitesplus/888/CGPSAT

Matrix 2.6 Planning Future Services also assists a practice to take an overall look at their maturity in practice development planning.

Practices should consider key issues from the CGSAT for discussion at GP cluster meetings where there may be potential to identify common themes that might be addressed through agreed actions.
GP Cluster Network Development Domain

GUIDANCE NOTE ON THE NATIONAL PRIORITIES FOR GENERAL PRACTICE 2015/16 - TARGETTING THE PREVENTION AND EARLY DETECTION OF CANCER

Introduction

Cancer is one of the three leading causes of death in Wales, lung and digestive system cancers being the major contributors. Cancer also makes a large contribution to the gap in healthy life expectancy between the most and least deprived populations. This gap is widening. There is a range of work being undertaken in Wales to prevent, diagnose and treat cancers, including initiatives to encourage healthy behaviours and to increase uptake of screening programmes (Chief Medical Officer for Wales Annual Report 2012-13) (1+2).

In 2012 the Welsh Government set out its ambition for cancer services in Wales (Together for Health - Cancer Deliver Plan; Our Vision) (3). This identified the need to ‘improve our efforts to prevent cancer and further develop services in all parts of Wales to close the gap between the most and least deprived communities, and compare better with the best in Europe’ (4).

Aim

To support the delivery of the Cancer Delivery Plan this national priority will support practice teams to:

- Look at problems and best practice in relation to the prevention and early detection of cancer
- Address barriers and improve services through the development, delivery and monitoring of actions.
- Share learning with members of their network, and, through networks, support Health Boards and NHS Wales in progressing the Cancer Delivery Plan.

Action

The Actions required for this priority are:

- To carry out Significant Event Analyses
- To summarise learning and identify appropriate actions for inclusion in the Practice Development Plan
- To share analyses and progress with the network and the wider health board
- To propose actions for the GP Cluster Network Action Plan where appropriate

For this priority GP Practices will review the care of patients newly diagnosed, with lung (including mesothelioma); digestive system cancer (stomach cancer; lung cancer; liver cancer; pancreatic cancer; bowel cancer) and ovarian cancer, using a Significant Event Analysis tool (Appendix 1). The care of all patients diagnosed between 1/1/2015 and 31/12/2015 with these conditions should be reviewed.122

The Significant Event Analysis tool encourages broad discussion of cancer detection and prevention. Reference to the National Awareness and Early Diagnosis Initiative Pathway (NAEDI) (Appendix 2) may be helpful for structuring reviews and discussions. General

122 Where practices do not identify Lung or GI cancers or ovarian cancers within the specified time period, they should discuss alternative analyses with the Health Board.
Practitioners should ensure that this wider picture is considered, in particular how individual cases reflect the aims of Outcome 1 and Outcome 2 of the Cancer Delivery Plan (outlined below). General Practice and the wider community network have key roles to play in both outcome areas.

**Outcome 1 - People are aware of and are supported in minimising their risk of cancer through healthy lifestyle choices (5, 6 appendix 3)**

- More people are supported to quit smoking
- More people are aware of the health harms of smoking, above limits alcohol consumption, the broader benefits of physical activity and healthy eating
- More people achieve a healthy weight through weight management support
- More people are physically active as a natural part of their everyday life and undertake sufficient physical activity to benefit their health

**Outcome 2 - Cancer is detected quickly where it does occur or recur (7,8,9)**

- Easier access to GPs, pharmacists, dentists and opticians
- More information and support services and easier to find such as through local pharmacies
- More doctors and nurses available 24 hours a day, 365 days a year
- More direct access to diagnostic tests for the GP to refer to
- A greater range of local services meaning less need to travel, particularly for diagnosis and care after treatment
- Reduced travel costs for patients
- Better take up of population screening
- Prompt and appropriate access to assessment and treatment known to work to increase the chance of cure and reduce side effects
- More information on reducing the risk of developing cancer, recognising the symptoms suggestive of early cancer and what services to expect available by telephone and on-line
- More men going sooner to their GP or other health services

Practices may find it helpful to schedule these reviews as part of their multi-disciplinary practice meetings.

Themes should be gathered and shared with the wider network through Cluster meetings. Where appropriate, actions should inform the Cluster Network Annual Report. Actions may include dialogue with the health board to address issues such as timely access to specialist investigations and advice.

Serious incidents and significant barriers to patient care should be highlighted immediately through local governance processes. Agreed actions to address such issues should be included in local plans.

Progress across the cluster should be summarised in the Cluster Network Annual Report. This will help to inform the assessment of health board progress against the Cancer Delivery Plan and will enable monitoring of actions for this National Priority.
References/ Resources


This guide produced by Macmillan provides a helpful summary of NICE guidance for different types of cancer and the referral criteria. This may be helpful when looking at the significant event audit.
Appendix 1

[INSERT NAME of PRACTICE]

Cancer Diagnosis Significant Event Audit (SEA), 2015/16

INIDIVDUAL CASE REPORT TEMPLATE

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of diagnosis</td>
<td></td>
</tr>
<tr>
<td>Age of patient at diagnosis</td>
<td></td>
</tr>
<tr>
<td>Is the patient currently alive?</td>
<td>(if not alive, please give date of death)</td>
</tr>
<tr>
<td>Date of SEA review</td>
<td></td>
</tr>
</tbody>
</table>

1. What happened?

Describe the process to diagnosis for the patient, including dates of consultations, referral and diagnosis. Consider (for instance): The key consultation at which diagnosis was made. Consultations for this patient in the practice in the year prior to diagnosis and the referral process. How often had the patient been seen and for what reason(s)? Had he/she been seen by the Out of Hours service, at A&E or in secondary care clinics? Was there any delay on the part of the patient in presenting with their symptoms? Where there any risk factors for cancer and had any steps been taken to address these?) Is there any record that presentation was prompted by information/ or advice from other agencies - such as community pharmacists or the third sector? Had appropriate screening taken place?
2. Why did it happen?

Reflect on the process of diagnosis. Was this as good as it could have been? If so, what were the factors that contributed to speedy and/or appropriate diagnosis in primary care? If there was some delay in diagnosis, what were the underlying factors that contributed to this? Were the reasons for any delay acceptable or appropriate? Was the referral made through the appropriate route? Did referral make use of an appropriate template or include the required information? Where appropriate tests carried out or would improved access to investigations have aided the diagnostic pathway?

3. What has been learned?

Describe the discussion at the team meeting. Demonstrate that reflection and learning have taken place on an individual or team basis and that relevant team members have been involved in considering the process of diagnosis. Consider, for instance: a lack of education or training; the need to follow systems of procedures; the importance of team working or effective communication. Consider the role
of the NICE Referral guidelines for suspected cancer and their usefulness to primary care teams.

Learning point 1:

Learning point 2:

Learning point 3:

Learning point 4:

4. What has been changed?

Outline the action(s) agreed and implemented, where this is relevant or feasible. Consider, for instance: if a protocol has been amended, updated or introduced; how this was done, who it will involve, and how this change will be monitored. Are there things individuals or the practice will do differently? Consider both administrative and clinical issues.

What was effective about this SEA?

Developed from the Cancer SEA Template- Durham University in conjunction with the RCGP- Professor Greg Rubin ((2010)https://www.dur.ac.uk/school.health/erdu/cancer_audit/cancersea/)
Appendix 2

NAEDI (National Awareness and Early Diagnosis Initiative) Pathway - (7)
### Top six causes of all cancers in men and women

Risk factors of the 158,700 cancers diagnosed in men and 155,600 cancers diagnosed in women each year.

<table>
<thead>
<tr>
<th>Ranking</th>
<th>Men</th>
<th>Risk factor %</th>
<th>Women</th>
<th>Risk factor %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Tobacco</td>
<td>23</td>
<td>Tobacco</td>
<td>15.6</td>
</tr>
<tr>
<td>2</td>
<td>Lack of fruit &amp; vegetables</td>
<td>6.1</td>
<td>Overweight</td>
<td>6.9</td>
</tr>
<tr>
<td>3</td>
<td>Occupational hazard</td>
<td>4.9</td>
<td>Infection</td>
<td>3.7</td>
</tr>
<tr>
<td>4</td>
<td>Alcohol</td>
<td>4.6</td>
<td>Exposure to sun &amp; sunbeds</td>
<td>3.6</td>
</tr>
<tr>
<td>5</td>
<td>Overweight</td>
<td>4.1</td>
<td>Lack of fruit &amp; vegetables</td>
<td>3.4</td>
</tr>
<tr>
<td>6</td>
<td>Exposure to sun &amp; sunbeds</td>
<td>3.5</td>
<td>Alcohol</td>
<td>3.3</td>
</tr>
</tbody>
</table>

Source: Cancer Research UK
Annex 6A

National Priority Area

Prevention and early Detection of Digestive, Lung and Ovarian Cancers

End year report 2015/16

In the primary care setting, where the incidence of cancer is low, it can be difficult to differentiate between common systems of mild self-limiting illness and early indicators of malignancy in that population. However, by reviewing individual cases it is possible to develop our understanding of system delays and to identify and share good practice in order to improve early diagnosis. This reflects work developing through the International Cancer Benchmarking Partnership in Wales http://www.icbp.wales.nhs.uk/home and ensures that primary care teams are engaged in that shared learning.

Summary Data

(Include a chart summarising the cases reviewed. Also describe other information found during significant event analysis such as data relating to relevant lifestyle factors and availability of investigations. A brief fictitious example is given for illustration purposes).

<table>
<thead>
<tr>
<th>Early detection cancer</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>patient</td>
<td>cancer type</td>
</tr>
<tr>
<td>1 lung</td>
<td>2 gp surgery</td>
</tr>
<tr>
<td>2 colon</td>
<td>n/a</td>
</tr>
<tr>
<td>3 bile duct</td>
<td>4 gp surgery</td>
</tr>
<tr>
<td>4 lung</td>
<td>4 gp surgery</td>
</tr>
<tr>
<td>5 pancreas</td>
<td>5 gp surgery</td>
</tr>
<tr>
<td>6 lung</td>
<td>2 gp surgery</td>
</tr>
<tr>
<td>7 colon</td>
<td>2 gp surgery</td>
</tr>
<tr>
<td>8 lung</td>
<td>2 gp surgery</td>
</tr>
<tr>
<td>8 stomach</td>
<td>gp surgery</td>
</tr>
<tr>
<td>10 lung</td>
<td>n/a</td>
</tr>
</tbody>
</table>

Documentation of smoking history was well documented with repeated offers of smoking cessation advice.

BMI was sometimes recorded but support was less evident.

There was good use of chest x-ray for most patients and these were actioned quickly with good support from radiology.

Access to ultrasound was slow although abnormal reports were received quickly.

Key Learning Points
Important learning points should be identified from the individual significant event analysis discussions. These should include recurring themes and less frequent important events. They should include positive and negative lessons - to ensure good activities are shared and encouraged, as well as identifying issues that require improvement. The learning should also reflect lessons relevant to the practice and those important to the wider team. Fictitious learning is given for illustration purposes."

- Continuity of care is important and where possible follow-up and actions should be arranged with the same doctor.
- GPs need to receive feedback from consultants on downgrades which should include a clear explanation as to why this has happened.
- Any down-grades should be forwarded to the referring doctor for action (with appropriate colleague cover if this is likely to be delayed).
- Early urgent ultrasounds should be considered for patients with abnormal liver function tests.
- Patients with copd and worsening symptoms should have appropriate investigation and referral if indicated.

**Actions Taken Within the Practice**

(Actions taken should be shared for wider discussion and learning. Actions which have not been completed should also be described, including any problems or barriers encountered which have prevented delivery. Actions should include those taken within the practice and those requiring wider support. Fictitious actions are given for illustration purposes.)

- Where possible patients with suspicion of cancer who have investigations should have appropriate follow up booked with the same doctor. Further discussion planned in the practice team meeting but doctor’s actioning in interim.
- Administration staff to track USC cancer referrals and chase further information where needed. Practice now using WCCG and Assistant practice Manager monitoring those referrals flagged as USC.
- Appropriate requests for u/s should be flagged as USC or discussed with the radiologist.
- System implemented to ensure downgrades are shared with the referring doctor. Letters are forwarded through Docman but any urgent action taken by the doctor receiving the mail.
- Poor communication regarding down grades from secondary care colleagues discussed at cluster and forwarded to health board.

**Issues taken forward to Cluster discussion**

**Issues for discussion with the Cancer Multi Disciplinary Team or Local Health Board**
GP Cluster Network Development Domain
GUIDANCE NOTE ON THE NATIONAL PRIORITIES FOR QUALITY AND PRODUCTIVITY INDICATORS - END OF LIFE CARE

Introduction

“Dying is a social matter; how well we care for people who are dying reflects on how we care as a society. Where death can be expected we must be prepared to have honest and open conversations about the end of life. It should not be a taboo subject. Preparing and planning for the end of life with the involvement of family, carers and professionals is essential to the delivery of high quality care. We must reach into communities to support people, if they wish, to remain in their home or place of care at the end of life.”

Professor Mark Drakeford (Minister for Health and Social Services) - Together for Health - Delivering End of Life Care (2013)(1).

The primary care team is central to the delivery of high quality end of life care. Primary care teams have longitudinal relationships with patients and their carers, and essential skills in patient centred, holistic care. They are ideally placed to co-ordinate care with other service providers, and manage the worry and stress present at the end of life. Having open and honest conversations, where they are wanted, is essential to giving patients and their carers the time to adjust and make plans for death. This can help ensure effective planned care at difficult times and reduce the risk of crisis management. (2,3)

Many General Practitioners and their teams will have already carried out work to improve end of life care. However, evidence would still suggest that too many people are not dying in their place of choice. Most patients continue to die in hospital even though many could have been supported to die elsewhere (Appendix 1 illustrates this pattern). There is further potential to redesign End of Life care to provide more efficient and effective services which better meet the needs of patients and their carers.

Aim

The aim of this priority is:

- To support general practitioners to review the experience of patients at End of Life
- To support general practitioners to identify and address issues in relation to delivering high quality end of life care.
- To support general practitioners to share information with members of their network, and, through networks, to support Health Boards/
- To encourage general practitioners to monitor progress (or maintenance of high quality) in the delivery of End of Life Care through further reviews.

Action

The Action required for this priority is:

- Identify all deaths occurring between 1st January 2015 and 31st December 2015.
- Use a significant event analysis approach to assess delivery of end of life care (with a particular focus on continuity of care). This analyses where possible, should include a review of contacts by the multidisciplinary team in the last two weeks of life, a review
of the completion of DNACPR forms; a review of the completion of out of hours handover forms; a review of the availability of “Just in Case” boxes and a review of Emergency admissions of patients at the end of life. This significant event analysis should be carried out for 2/1000 registered patients whose deaths occurred between 1st January 2015 and 31st December 2015).

- To summarise significant event analysis data, and any arising issues and actions identified, for sharing with the network and the wider health board (Annex 7A refers)
- To establish a review cycle, to monitor progress (or maintenance of high quality), with further submission of reports to the GP cluster and wider health board as appropriate.

Practices should identify:
- Any appropriate actions to be included in the Practice Development Plan.
- Themes for discussion in the cluster network
- Issues to be raised with local partners and the Health Board

The practice should contribute outcomes of this work to the Cluster Network Annual Report including: summary of key themes, actions and outcomes for the local community.

Practices may find the following resources helpful in developing this work:
- [http://wales.pallcare.info/](http://wales.pallcare.info/) All Wales Palliative Care website - valuable source of templates (Integrated Care Priorities/ Advanced Care Plans/ DNACPR forms etc) and other information in relation to palliative care

References/ Resources

2. [http://www.rcgp.org.uk/clinical-and-research/clinical-resources/~/media/Files/CIRC/Matters%20of%20Life%20and%20Death%20FINAL.ashx](http://www.rcgp.org.uk/clinical-and-research/clinical-resources/~/media/Files/CIRC/Matters%20of%20Life%20and%20Death%20FINAL.ashx) Matters of Life and Death RCGP/RCN
4. [http://www2.nphs.wales.nhs.uk:8080/PrimaryCareQITDocs.nsf/($All)/89886EB59AB57E1180257AEE004B221D/$File/End of life care main document January Final 2013.docx?OpenElement](http://www2.nphs.wales.nhs.uk:8080/PrimaryCareQITDocs.nsf/($All)/89886EB59AB57E1180257AEE004B221D/$File/End of life care main document January Final 2013.docx?OpenElement) Primary Care Quality and Information Service - End of Life Care Case review
### Appendix 1

#### End of Life Care

**Individual Case Report Template**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of diagnosis</td>
<td></td>
</tr>
<tr>
<td>Age of patient at diagnosis</td>
<td></td>
</tr>
<tr>
<td>Case Identifier / practice patient number</td>
<td></td>
</tr>
<tr>
<td>Date of death</td>
<td></td>
</tr>
<tr>
<td>Place of death</td>
<td></td>
</tr>
<tr>
<td>Date placed on practice Palliative Care Register</td>
<td></td>
</tr>
<tr>
<td>Date of this review.</td>
<td></td>
</tr>
</tbody>
</table>

1. **What happened?** Focus on the Patient’s/carer’s experience
2. **How did it happen?** Focus on how ‘well’ the End of Life care for the patient was organised?

<table>
<thead>
<tr>
<th>Question</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was the patient on the primary care Practice Palliative Care Register at the time of death?</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Preferred place of death discussed and recorded</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Anticipatory care considered and recorded (not all patients will wish to have an anticipatory care plan)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Did the patient have a named GP lead</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>OOH informed of patient entering onto the All Wales Integrated Care priorities for the Last Days of Life or other End of Life Pathway</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td><strong>Ongoing Management</strong> – PRN (only when required) medications available for the following symptoms in anticipation of; pain/nausea &amp; vomiting/agitation/respiratory tract secretions</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>DNACPR discussed and recorded in the Medical notes (not all patients will wish to complete a DNACPR)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Were there any unplanned/unscheduled admissions during the final days?</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>
3. **What has been learned?** What did the practice learn from reflection?

Learning point 1:

Learning point 2:

Learning point 3:

Learning point 4:

4. **What may you need to change at a practice level?** (or what has already been changed)

Which themes were identified as issues in this case review
National Priority Area

End of Life Care

Practice Report 2015/16

The organisation and delivery of end of life care can prove challenging across clinical teams and between routine and unscheduled care services. It is therefore important to create opportunities for teams to communicate, reflect on the care provided and identify opportunities for improvement. This approach will also help to ensure that good practice is embedded in routine care and monitored through local reporting arrangements.

Shared Data

(To enable cluster discussion the same data measures should be shared. This is to facilitate peer review and discussion. It should be recognised that data will not be directly comparable due to differences in practice populations and case selection. The use of tables and graphs is not essential as long as the information is present. Fictitious example data is shown for illustration purposes.)

<table>
<thead>
<tr>
<th>patient</th>
<th>diagnosis</th>
<th>time on register (in days)</th>
<th>preferred place of death</th>
<th>Actual place of death</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>lung cancer</td>
<td>60</td>
<td>home</td>
<td>hospice</td>
</tr>
<tr>
<td>b</td>
<td>bowel cancer</td>
<td>210</td>
<td>home</td>
<td>home</td>
</tr>
<tr>
<td>c</td>
<td>copd</td>
<td>80</td>
<td>home</td>
<td>hospital</td>
</tr>
<tr>
<td>d</td>
<td>ovarian cancer</td>
<td>240</td>
<td>not stated</td>
<td>home</td>
</tr>
<tr>
<td>e</td>
<td>renal failure</td>
<td>x</td>
<td>not stated</td>
<td>hospital</td>
</tr>
<tr>
<td>f</td>
<td>dementia</td>
<td>x</td>
<td>residential home</td>
<td>hospital</td>
</tr>
<tr>
<td>g</td>
<td>heart failure</td>
<td>x</td>
<td>not stated</td>
<td>hospital</td>
</tr>
<tr>
<td>h</td>
<td>prostate cancer</td>
<td>640</td>
<td>not stated</td>
<td>hospital</td>
</tr>
<tr>
<td>i</td>
<td>heart failure</td>
<td>x</td>
<td>not stated</td>
<td>hospital</td>
</tr>
<tr>
<td>j</td>
<td>copd</td>
<td>x</td>
<td>not stated</td>
<td>hospital</td>
</tr>
</tbody>
</table>
Key Learning Points

(Important learning points should be identified from the individual significant event analysis discussions. These should include recurring themes and less frequent important events. They should include positive and negative lessons - to ensure good activities are shared and encouraged, as well as identifying issues that require improvement. The learning should also reflect lessons relevant to the practice and those important to the wider team. Fictitious learning is given for illustration purposes.)

- The practice palliative care register was dominated by patients with a diagnosis of cancer. The team recognised the need to identify patients with chronic conditions or frailty who may be approaching the end of life.
- Few patients had Anticipatory Care Planning in place with limited evidence that this had been discussed with the patient. Reflections indicated a need to improve understanding of rationale for ACP and how this could be delivered in practice.
- Attendance at MDT meetings was excellent- supporting effective team working and care co-ordination. This was identified as being extremely important in delivering good quality end of life care.

Actions Taken within the Practice

(Actions taken should be shared for wider discussion and learning. Actions which have not been completed should also be described, including any problems or barriers encountered which have prevented delivery. Actions should include those taken within the practice and those requiring wider support. Fictitious actions are given for illustration purposes.)

- Ensure that patients in residential homes are added to the palliative care register where this is indicated following Enhanced Service review. This is ongoing.
• All MDT team members to be aware of the importance of identifying End of Life care needs and the triggers which can prompt patient identification. These patients to be discussed with a partner and in the next Palliative Care meeting. This is ongoing.

• Doctors in the practice to undertake online training in relation to Advanced Care Planning and then to discuss a practice meeting. Doctors have undertaken the relevant training and this is on the agenda for a future practice meeting.

• Benefits of regular well attended MDTs shared with cluster. This has been discussed in the cluster where concerns were raised regarding other practices where engagement was a problem.

Actions taken forward to cluster discussions

Issues for discussion with Multi Disciplinary Team
GUIDANCE NOTE ON THE NATIONAL PRIORITIES FOR GENERAL PRACTICE 2015/16 - MINIMISING THE HARMS OF POLYPHARMACY

Introduction

The 2013/14 QOF QP indicators supported the identification of patients most at risk of unscheduled episodes of urgent care, to encourage collaboration between services to meet the needs of the most vulnerable patients. This work included the development of anticipatory care plans and multidisciplinary team working to improve the coordination of care.

It is estimated that between 5-17% of hospital admissions may be associated with adverse drug reactions\(^1\). Effective medicines management plays a significant role in minimising the risk of adverse events and hospital admission QOF Indicator Medicines 11 rewards the delivery of high quality systems of care that offer regular medication review.

For 2015/16 contractors are supported to compliment this work and further develop medicines management systems to more effectively identify and manage medication related risks.

This approach will be further developed in subsequent years.

Background

Elderly patients are often at high risk for significant morbidity or mortality and may have the potential to benefit most from many treatments and preventive therapies. However it is also widely recognised that the concurrent use of multiple medications or ‘poly-pharmacy’ may increase risks for this group.

Routine prescribing data does not provide information in relation to the prevalence of poly-pharmacy for different population groups. However a study by Guthrie and Makubate (2012) found that 16.4 per cent of older patients (65 years and above) were receiving 10 or more medications and the PRACtIcE Study, of English general practices found 9.7 per cent were receiving more than 10 medications (Avery \textit{et al} 2012b).

Prudent medicine and patient centred care

The prudent healthcare approach seeks to avoid the administration of more medicine than is clinically indicated whilst also ensuring that appropriate preventive therapies are considered at all ages.

The aim is not to simply reduce the numbers of medicines being taken, but to ensure that prescribing choices are well informed, likely to benefit the patient and that any risks are understood and appropriately monitored. It is estimated that up to 50\% of medications are not taken as prescribed. The medication review is an opportunity to ensure that the most effective treatments are prioritised and used effectively.
For many elderly patients there are a number of issues for consideration, including poly-pharmacy, the use of high-risk medicines, transition between services, medicines management in Care Home settings and end of life care.

The ‘No Tears’ tool (Appendix 1) is a simple, structured approach, designed for use in General Practice. All tools have limitations and do not replace careful clinical decision-making. However, structured, systematic review can highlight inappropriate prescribing and identify opportunities to improve individual care and local medicines management systems.

For 2015/16 Contractors will:

1. Identify and record numbers and rates for patients aged 85 years or more receiving 6 or more medications (excluding dressings etc)
2. Undertake face to face medication reviews, using the ‘No Tears’ approach (Appendix 1) for at least 60% of the cohort defined in 1. above (for a minimum number equivalent to 5/1000 registered patients. If the minimum number of reviews cannot be undertaken because of the small size of the cohort defined in 1 above, consider reducing the age limit until the minimum is reached.)
3. Identify any actions to be addressed in the Practice Development Plan.
4. Summarise themes and actions for review with the cluster network and share information with the Health Board as required.
Resources

Polypharmacy and medicines optimization: Making it safe and sound

Martin Duerden, Tony Avery and Rupert Payne. Kings Fund 2013

Wales polypharmacy guidance (AWPTC- in development)


Using the NO TEARS tool for medication review

BMJ 2004; 329 doi

http://dx.doi.org/10.1136/bmj.329.7463.434

STOPP (Screening Tool of Older Persons’ potentially inappropriate Prescriptions): application to acutely ill elderly patients and comparison with Beers’ criteria


Medication Comprehension and Safety in Older Adults


NHS Scotland Polypharmacy Guidance


Prescribing for Older People. WeMeReC Bulletin, June 2011 www.wemerec.org


Ten principles for medicines use in older people

Appendix 1

The ‘NO TEARS’ tool

Dr Tessa Lewis: *BMJ* 2004;329:434

Issue to consider: -

- **Need and indication**
- **Open questions**
- **Tests and monitoring**
- **Evidence and guidelines**
- **Adverse events**
- **Risk reduction or prevention**
- **Simplification and switches**

**Need and indication**—Does the patient know why he/she takes each drug? Is the drug still needed? Was long term treatment intended? Is the dose appropriate? Has the diagnosis been refuted? Would non-pharmacological treatments be better?

**Open questions**—Give the patient the opportunity to express their views by asking questions: “I realise a lot of people don't take all their tablets. Do you have any problems?” “Can I check that we both agree what you're taking regularly?” or “Do you think your tablets work?” Compare replies with the number of prescription requests.

**Tests and monitoring**—Assess disease control. Are any of his conditions undertreated? Get advice on appropriate monitoring from prescribing guidelines such as the *British National Formulary* or the US *Physicians' Desk Reference* and other primary care documents.

**Evidence and guidelines**—Has the evidence base changed since the prescription was initiated? Do the prescribing guidelines indicate that any of his drugs are now less suitable for prescribing? Is the dose appropriate? (For example, dose optimisation of angiotensin converting enzyme inhibitors in cardiac failure.) Are other investigations now advised, such as echocardiography or testing for *Helicobacter pylori*?
**Adverse events**—Does the patient have any side effects? Are complementary medicines or over the counter preparations being taken? Check for interactions, duplications, or contraindications. Remember the “prescribing cascade” (misinterpreting an adverse reaction as a new medical condition).
Frailty and Poly-pharmacy Practice Report

End of Year Report

The requirement was to undertake face to face medication reviews, using the ‘No Tears’ approach for at least 60% of Patients aged 85 years or more receiving 6 or more medications (for a minimum number equivalent to 5/1000 registered patients. If the minimum number of reviews could not be undertaken because of the small size of the cohort defined in 1 above, practices were to consider reducing the age limit until the minimum was reached.)

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice population</td>
<td></td>
<td></td>
</tr>
<tr>
<td>85 and over</td>
<td></td>
<td></td>
</tr>
<tr>
<td>85 and over on 6 or more meds (the cohort)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients reviewed (number and percentage of cohort)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average number of medications per patient reviewed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average number of medications per patient reviewed - after review</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Key learning points

- Xx
- Xx
- xx

Actions taken within the Practice

- XX
- XX
- X

Actions taken forward to cluster discussions

Issues for discussion with Multi Disciplinary Team