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To: GPs in England

Regional Directors of Primary Care and Public Health

CCGs

NHS England and NHS Improvement
Skipton House
80 London Road
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Dear colleagues

31 March 2022

Update on Quality Outcomes Framework changes for 2022/23

To provide practice stability and support recovery, QOF for 2022/23 will be based on the indicator set already agreed for 2021/22, with the only changes being the introduction of two new Quality Improvement modules. Full reinstatement of QOF from 1 April is central to plans for recovery in long-term condition management within and beyond primary care.

The size of QOF has stayed the same at 635 points. The value of a QOF point in 2022/23 will be £207.56 and the national average practice population figure will be 9,374. There are no changes to QOF indicators or payment thresholds for 2022/23.

The Quality Improvement modules for 2022/23 are:

- Prescription Drug Dependency
- Optimising Access to General Practice

Further detailed information on the data recording requirements and payment is included in the QOF Guidance for 2022/23. Any changes relative to the 2021/22 QOF Guidance are highlighted in yellow (with the exception of Section 5 describing the Quality Improvement modules, all of which is new).

Thank you for your continued dedication and hard work.

Yours sincerely,

Melanie Craig

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Annex A – QOF guidance for 2022/23

Contents

Section 1: Introduction

Purpose of this document

This document provides additional guidance on the interpretation and verification of the QOF indicators for 2022/23 in England, which are listed in Annex D of the Statement of Financial Entitlements Directions (SFE)[1]. It is effective from 1 April 2022 and replaces versions issued in previous years.

This document covers:

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

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

Definition of 'commissioner'

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

Additional Indicator information

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

Clinical and public health indicators

[1] https://www.gov.uk/government/publications/nhs-primary-medical-services-directions-2013

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

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

Indicator numbering

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

Where an indicator has been developed through the NICE led process[2] they will also be annotated with their NICE menu ID number (NICE [year] menu ID: NMXX). If a NICE developed indicator has been amended during negotiations this will be annotated with 'based on NMXX'. References to NICE guidance throughout this document relate to the guidance that has been used to underpin the stated indicators. In some cases, new or updated guidance may have been recently published, or will be published before the end of the QOF year. These guidelines will be reviewed by NICE in due course and any recommendations concerning amending current indicators or development of new indicators will be published in future NICE indicator menus for consideration by relevant parties.

Identifying the target population or disease register

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

[2] https://www.nice.org.uk/media/default/Get-involved/Meetings-In-Public/indicator-advisory-committee/ioc-process-guide.pdf

activity is clinically appropriate, but they may not meet the criteria as defined by the QOF register. Contractors are asked to hold this in mind when developing call/recall systems.

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

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

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

Quality improvement indicators

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

Reporting, payment calculation and verification

Reporting

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

The clinical codes and logical extraction sequence used in this data collection is defined in a series of technical documents – the Business Rules. These are based entirely on SNOMED codes and associated dates, combined with patient characteristics (e.g. age and sex). SNOMED codes are an NHS standard. Contractors using proprietary coding systems and/or local/practice specific codes will need to be aware that these codes will not be recognised within QOF reporting. The Business Rules are available on the NHS Digital website[3].

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

Payment calculation and achievement

[3] NHS Digital. http://content.digital.nhs.uk/qofesextractspecs

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

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

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

Verification

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

Commissioners and practices will be aware of the requirements of access to patient identifiable data, in particular that they should:

- Obtain the minimum necessary information for the specific purpose
- Anonymise data where possible

Where patients have expressed a desire that their information is not shared for this purpose, practices will need to advise the commissioner and make an appropriate note in the record. It is recommended that practices record access to confidential patient data in the relevant patient record, so that an audit trail is in place to fulfil the obligations of the practice towards their patients and that of commissioners to practices.

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

Disputes

When a QOF related contractual dispute arises, the commissioner and contractor would be expected to make every reasonable effort to communicate and co-operate

with each other with a view to resolving the dispute without the need to refer it for formal determination by NHS Resolution (Primary Care Appeals) (or in certain cases, the courts). Further information is available in the SFE.

Section 2: Summary of all indicators[4]

Clinical domain (401 points)

This domain applies to all contractors participating in QOF.

Atrial fibrillation (AF)	Points	Thresholds
Records		
AF001. The contractor establishes and maintains a register of patients with atrial fibrillation	5	N/A
Ongoing management		
AF006. The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA_2DS_2-VASc score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous $CHADS_2$ or CHA_2DS_2-VAS_c score of 2 or more)	12	40-90%
AF007. In those patients with atrial fibrillation with a record of a CHA_2DS_2-VAS_c score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy	12	40-70%

Secondary prevention of coronary heart disease (CHD)	Points	Thresholds
Records		
CHD001. The contractor establishes and maintains a register of patients with coronary heart disease	4	N/A
Ongoing management		
CHD005. The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken	7	56–96%
CHD008. The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less	12	40-77%

[4] The 'summary of indicators' section is an extract from Annex D of the SFE.

CHD009. The percentage of patients aged 80 years or over with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	5	46-86%

Heart failure (HF)	Points	Thresholds
Records		
HF001. The contractor establishes and maintains a register of patients with heart failure	4	N/A
Initial diagnosis		
HF005. The percentage of patients with a diagnosis of heart failure on or after 1 April 2021 which: 1. Has been confirmed by an echocardiogram or by specialist assessment between 3 months before and 6 months after entering on to the register; or 2. If newly registered in the preceding 12 months, with no record of the diagnosis originally being confirmed by echocardiogram or specialist assessment, a record of an echocardiogram or a specialist assessment within 6 months of the date of registration.	6	50–90%
Ongoing management		
HF003. In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB	6	60–92%
HF006. The percentage of patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, who are currently treated with a beta-blocker licensed for heart failure	6	60-92%
HF007. The percentage of patients with a diagnosis of heart failure on the register, who have had a review in the preceding 12 months, including an assessment of functional capacity and a review of medication to ensure medicines optimisation at maximal tolerated doses	7	50-90%

Hypertension (HYP)	Points	Thresholds
Records		
HYP001. The contractor establishes and maintains a register of patients with established hypertension	6	N/A
Ongoing management		

HYP003. The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less	14	40-77%
HYP007. The percentage of patients aged 80 years and over with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	5	40-80%
Peripheral arterial disease (PAD)	**Points**	**Thresholds**
Records		
PAD001. The contractor establishes and maintains a register of patients with peripheral arterial disease	2	N/A
Stroke and transient ischaemic attack (STIA)	**Points**	**Thresholds**
Records		
STIA001. The contractor establishes and maintains a register of patients with stroke or TIA	2	N/A
Ongoing management		
STIA007. The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 12 months that an anti-platelet agent, or an anti-coagulant is being taken	4	57–97%
STIA010. The percentage of patients aged 79 years or under with a history of stroke or TIA in whom the least blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less	3	40-73%
STIA011. The percentage of patients aged 80 years and over with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	2	46-86%
Diabetes mellitus (DM)	**Points**	**Thresholds**
Records		
DM017. The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed	6	N/A
Ongoing management		

DM006. The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs)	3	57–97%
DM012. The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 12 months	4	50–90%
DM014. The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register	11	40–90%
DM019. The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less	10	38-78%
DM020. The percentage of patients with diabetes, on the registers, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months	17	35-75%
DM021. The percentage of patients with diabetes, on the register, with moderate or severe frailty in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months	10	52-92%
DM022. The percentage of patients with diabetes aged 40 years and over, with no history of cardiovascular disease and without moderate or severe frailty, who are currently treated with a statin (excluding patients with type 2 diabetes and a CVD risk score of <10% recorded in the preceding 3 years)	4	50-90%
DM023. The percentage of patients with diabetes and a history of cardiovascular disease (excluding haemorrhagic stroke) who are currently treated with a statin	2	50-90%

Asthma (AST)	Points	Thresholds
Records		
AST005. The contractor establishes and maintains a register of patients with asthma aged 6 years or over, excluding patients with asthma who have been prescribed no asthma related drugs in the preceding 12 months	4	N/A
Initial diagnosis		
AST006. The percentage of patients with a diagnosis of asthma on or after 1 April 2021 with either: 1. A record of spirometry and one other objective test (FeNO or reversibility or variability) between 3 months before and 6 months after diagnosis; or 2. If newly registered in the preceding 12 months with a diagnosis of asthma recorded on or after 1 April 2021 but no record of objective tests being performed at the date of registration, with a record of spirometry and one other objective test (FeNO or reversibility or variability) recorded within 6 months of registration	15	45–80%
Ongoing management		
AST007. The percentage of patients with asthma on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using a validated asthma control questionnaire, a recording of the number of exacerbations, an assessment of inhaler technique and a written personalised action plan	20	45–70%
AST008. The percentage of patients with asthma on the register aged 19 or under, in whom there is a record of either personal smoking status or exposure to second-hand smoke in the preceding 12 months	6	45–80%

Chronic obstructive pulmonary disease (COPD)	Points	Thresholds
Records		
COPD009. The contractor establishes and maintains a register of: 1. Patients with a clinical diagnosis of COPD before 1 April 2021 and 2. Patients with a clinical diagnosis of COPD on or after 1 April 2021 whose diagnosis has been confirmed by a quality assured post bronchodilator spirometry FEV_1/FVC ratio below 0.7 between 3 months before and 6 months after diagnosis (or if newly registered in the preceding 12 months a record of an FEV_1/FVC ratio below 0.7 recorded within 6 months of registration); and 3. Patients with a clinical diagnosis of COPD on or after 1 April 2021 who are unable to undertake spirometry	8	N/A
Ongoing management		
COPD010. The percentage of patients with COPD on the register, who have had a review in the preceding 12 months, including a record of the number of exacerbations and an assessment of breathlessness using the Medical Research Council dyspnoea scale	9	50–90%
COPD008. The percentage of patients with COPD and Medical Research Council (MRC) dyspnoea scale ≥3 at any time in the preceding 12 months, with a subsequent record of an offer of referral to a pulmonary rehabilitation programme (excluding those who have previously attended a pulmonary rehabilitation programme)	2	40-90%

Dementia (DEM)	Points	Thresholds
Records		
DEM001. The contractor establishes and maintains a register of patients diagnosed with dementia	5	N/A
Ongoing management		
DEM004. The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months	39	35–70%

Depression (DEP)	Points	Thresholds
Initial management		
DEP003. The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis	10	45–80%

Mental health (MH)	Points	Thresholds
Records		
MH001. The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy	4	N/A
Ongoing management		
MH002. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate	6	40–90%
MH003. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months	4	50–90%
MH006. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months	4	50-90%
MH007. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months	4	50-90%
MH011. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of a lipid profile in the preceding 12 months (in those patients currently prescribed antipsychotics, and/or have pre-existing cardiovascular conditions, and/or smoke, and/or are overweight (BMI of ≥23 kg/m2 or ≥25 kg/m2 if ethnicity is recorded as White)) or preceding 24 months for all other patients	8	50-90%
MH012. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months	8	50-90%

Cancer (CAN)	Points	Thresholds
Records		
CAN001. The contractor establishes and maintains a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers diagnosed on or after 1 April 2003'	5	N/A
Ongoing management		
CAN004. The percentage of patients with cancer, diagnosed within the preceding 24 months, who have a patient Caner Care Review using a structured template recorded as occurring within 12 months of the date of diagnosis	6	50–90%
CAN005. The percentage of patients with cancer, diagnosed within the preceding 12 months, who have had the opportunity for a discussion and informed of the support available from primary care, within 3 months of diagnosis	2	70-90%

Chronic kidney disease (CKD)	Points	Thresholds
Records		
CKD005. The contractor establishes and maintains a register of patients aged 18 or over with CKD with classification of categories G3a to G5 (previously stage 3 to 5)	6	N/A

Epilepsy (EP)	Points	Thresholds
Records		
EP001. The contractor establishes and maintains a register of patients aged 18 or over receiving drug treatment for epilepsy	1	N/A

Learning disability (LD)	Points	Thresholds
Records		
LD004. The contractor establishes and maintains a register of patients with learning disabilities	4	N/A

Osteoporosis: secondary prevention of fragility fractures (OST)	Points	Thresholds
Records		
OST004. The contractor establishes and maintains a register of patients: 1. Aged 50 or over and who have not attained the age of 75 with a record of a fragility fracture on or after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and 2. Aged 75 or over with a record of a fragility fracture on or after 1 April 2014 and a diagnosis of osteoporosis	3	N/A

Rheumatoid arthritis (RA)	Points	Thresholds
Records		
RA001. The contractor establishes and maintains a register of patients aged 16 or over with rheumatoid arthritis	1	N/A
Ongoing management		
RA002. The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 12 months	5	40–90%

Palliative care (PC)	Points	Thresholds
Records		
PC001. The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age	3	N/A

Non diabetic hyperglycaemia (NDH)	Points	Thresholds
Records		
NDH001. The percentage of patients with non-diabetic hyperglycaemia who have had an HbA1c or fasting blood glucose performed in the preceding 12 months	18	50–90%

Public health domain (160 points)

Public health domain

This domain applies to all contractors participating in QOF, with the exception of the additional services sub-domain (discussed below).

Blood pressure (BP)	Points	Thresholds
BP002. The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years	15	50–90%

Obesity (OB)	Points	Thresholds
Records		
OB002. The contractor establishes and maintains a register of patients aged 18 years or over with a BMI ≥30 in the preceding 12 months	8	N/A

Smoking (SMOK)	Points	Thresholds
Records		
SMOK002. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months	25	50–90%
Ongoing management		
SMOK004. The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 24 months	12	40–90%
SMOK005. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 months	25	56–96%

Vaccination and Immunisations (VI)	Points	Thresholds	Points at lower threshold
VI001. The percentage of babies who reached 8 months old in the preceding 12 months, who have received at least 3 doses of a diphtheria, tetanus and pertussis containing vaccine before the age of 8 months	18	90-95%	3
VI002. The percentage of children who reached 18 months old in the preceding 12	18	90-95%	7

months, who have received at least 1 dose of MMR between the ages of 12 and 18 months			
VI003. The percentage of children who reached 5 years old in the preceding 12 months, who have received a reinforcing dose of DTaP/IPV and at least 2 doses of MMR between the ages of 1 and 5 years	18	87-95%	7
VI004. The percentage of patients who reached 80 years old in the preceding 12 months, who have received a shingles vaccine between the ages of 70 and 79 years	10	50-60%	0

Public health domain – additional services sub-domain

The additional services sub-domain applies to contractors who provide additional services under the terms of the GMS contract and participate in QOF.

Cervical screening (CS)	Points	Thresholds
CS005. The proportion of women eligible for screening and aged 25-49 years at the end of period reported whose notes record that an adequate cervical screening test has been performed in the previous 3 years and 6 months	7	45-80%
CS006. The proportion of women eligible for screening and aged 50-64 years at the end of period reported whose notes record that an adequate cervical screening test has been performed in the previous 5 years and 6 months	4	45-80%

Quality improvement domain (74 points)

This domain applies to all contractors participating in QOF.

Prescription Drug Dependency	Points	Thresholds
QIPDD009. The contractor can demonstrate continuous quality improvement activity focused upon early prescription drug dependency as specified in the QOF guidance	27	N/A
QIPDD010. The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity focused on prescription drug dependency as specified in the QOF guidance. This would usually include participating in a minimum of two peer review meetings	10	N/A

Optimising Access to General Practice	Points	Thresholds
QIOA011. The contractor can demonstrate continuous quality improvement activity focused on optimising access to General Practice as specified in the QOF guidance	27	N/A
QIOA012. The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity focused on optimising access to General Practice as specified in the QOF guidance. This would usually include participating in a minimum of two network peer review meetings	10	N/A

Section 3: Clinical domain

Atrial fibrillation (AF)

Indicator	Points	Thresholds
Records		
AF001. The contractor establishes and maintains a register of patients with atrial fibrillation	5	N/A
Ongoing management		
AF006. The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA_2DS_2-VASc score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous CHADS2 or CHA_2DS_2-VAS_c score of 2 or more)	12	40-90%
AF007. In those patients with atrial fibrillation with a record of a CHA_2DS_2-VAS_c score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy	12	40-70%

AF – rationale for inclusion of indicator set

AF is the most common heart rhythm disorder (affecting approximately 2% of the adult population), and estimates suggest its prevalence is increasing. AF causes palpitations and breathlessness in many people, and it may also be asymptomatic and therefore go undetected. If left untreated AF is a significant risk factor for stroke and other morbidities: it is estimated that it is responsible for approximately 20% of all strokes and is associated with increased mortality and significant morbidity. Men are more commonly affected than women and the prevalence increases with age and in underlying heart disease, diabetes, obesity and hypertension[5].

AF001

AF001 Rationale

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

AF001 Reporting and verification

See indicator wording for requirement criteria.

[5] NICE NG196 (2021) Atrial fibrillation. http://www.nice.org.uk/Guidance/NG196

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

AF may resolve in some specific and limited situations. Contractors should also note that patients who have been recorded with AF resolved, continue to be at an increased risk of stroke compared to patients who have never had an episode of AF[6]. Contractors should consider the implications of this for individual patients before using the AF resolved code.

AF006 (NICE 2014 menu ID: NM81)

AF006 Rationale

The NICE guideline on atrial fibrillation[7] recommends that people with symptomatic or asymptomatic paroxysmal, persistent or permanent AF, atrial flutter or a continuing risk of arrhythmia recurrence after cardioversion back to sinus rhythm should have an assessment of their stroke risk using the CHA_2DS_2-VAS_c risk assessment tool.

The CHA_2DS_2-VAS_c system scores one point, up to a maximum of nine, for each of the following risk factors (except previous stroke or TIA, or age ≥75 which scores double, hence the '2'):

- C: congestive HF (one point)
- H: hypertension (one point)
- A_2: age 75 or over (two points)
- D: diabetes mellitus (one point)
- S_2: 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)

AF006 Reporting and verification

See indicator wording for requirement criteria.

Stroke risk assessment should be repeated on an annual basis unless the patient has previously scored 2 or more using either CHA_2DS_2-VAS_c at any time, or $CHADS_2$ prior to 1 April 2015.

AF007 (NICE 2015 menu ID: NM82)

AF007 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.

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

[7] NICE NG196 Atrial fibrillation (2021) http://www.nice.org.uk/Guidance/NG196

The risk of stroke is five times higher for patients with AF than for the general population, and 20–30% of all strokes are attributed to this arrhythmia.[8]The Stroke Association estimate that if AF were adequately treated, around 7,000 strokes would be prevented and over 2,000 lives saved every year in England alone.[9]

All patients with AF and a CHA_2DS_2-VAS_c score of two or above should be offered anti-coagulation therapy taking their bleeding risk into account. A CHA_2DS_2-VAS_c score of one in women (women under age 65 with no other risk factors) should be regarded as low risk and should not receive anti-coagulation. Men with a CHA_2DS_2-VAS_c score of one should be regarded as at intermediate risk and a group in whom anti-coagulation should be considered.

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

AF007 Reporting and verification

See indicator wording for requirement criteria.

The Business Rules will look for the latest CHA_2DS_2-VAS_c score in the patient record and if the score is equal to, or greater than two, the patient will be included in the denominator. If the patient does not have a CHA_2DS_2-VAS_c score, but does have a $CHADS_2$ score of greater than, or equal to two recorded before 1 April 2015, they will be included in the denominator.

Secondary prevention of coronary heart disease (CHD)

Indicator	Points	Thresholds
Records		
CHD001. The contractor establishes and maintains a register of patients with coronary heart disease	4	N/A
Ongoing management		
CHD005. The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken	7	56–96%

[8] https://www.nice.org.uk/sharedlearning/safe-and-effective-management-of-stroke-prevention-in-atrial-fibrillation
[9] https://www.stroke.org.uk/professionals/atrial-fibrillation-information-and-resources

CHD008. The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less	12	40-77%
CHD009. The percentage of patients aged 80 years and over with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	5	46-86%

CHD – rationale for inclusion of indicator set

CHD is the single most common cause of premature death in the UK[10]. 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.

CHD001

CHD001 Rationale

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

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

CHD001 Reporting and verification

See indicator wording for requirement criteria.

CHD005 (NICE 2015 menu ID: NM88)

CHD005 Rationale

NICE guidance[11] recommends all people who have had an MI should be offered aspirin (or clopidogrel if aspirin is contraindicated). Antiplatelet therapy with clopidogrel is equivalent to aspirin in preventing further cardiovascular events in people with coronary heart disease or ischaemic stroke.

CHD005 Reporting and verification

See indicator wording for requirement criteria.

CHD008 (NICE 2013 menu ID: NM68)

CHD008 Rationale

[10] bhf-cvd-statistics-uk-factsheet.pdf (ims.gov.uk)
[11] NICE NG185 Acute coronary syndromes (2020) http://guidance.nice.org.uk/NG185

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

CHD008 Reporting and verification

See indicator wording for requirement criteria

CHD009 (NICE 2019 menu ID: NM191)

CHD009 Rationale

This indicator measures the intermediate outcome of a blood pressure of 150/90 mmHg or less in people aged 80 years and over with coronary heart disease as recommended by the NICE clinical guideline for hypertension.[12]

CHD009 Reporting and verification

See indicator wording for requirement criteria.

Heart failure (HF)

Indicator	Points	Thresholds
Records		
HF001. The contractor establishes and maintains a register of patients with heart failure	4	N/A
Initial diagnosis		
HF005. The percentage of patients with a diagnosis of heart failure on or after 1 April 2021 which: 1. Has been confirmed by an echocardiogram or by specialist assessment between 3 months before and 6 months after entering on to the register; or 2. If newly registered in the preceding 12 months, with no record of the diagnosis originally being confirmed by echocardiogram or specialist assessment, a record of an echocardiogram or a specialist assessment within 6 months of the date of registration	6	50–90%
Ongoing management		

[12] NICE NG136 (2019, updated 2022) Hypertension in adults. http://www.nice.org.uk/guidance/ng136

HF003. In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB	6	60–92%
HF006. The percentage of patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, who are currently treated with a beta-blocker licensed for heart failure	6	60-92%
HF007. The percentage of patients with a diagnosis of heart failure on the register, who have had a review in the preceding 12 months, including an assessment of functional capacity and a review of medication to ensure medicines optimisation at maximal tolerated doses	7	50-90%

HF – rationale for inclusion of indicator set

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

HF001

HF001 Rationale

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

HF001 Reporting and verification

See indicator wording for requirement criteria.

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

- Register 1: patients with HF is used to calculate APDF for HF001, HF005, and HF007.
- Register 2: patients with HF due to left ventricular systolic dysfunction (LVSD) is used to calculate APDF for HF003 and HF006.

Register 1 is defined in indicator HF001. Register 2 is a sub-set of register 1 and is composed of patients with a diagnostic code for LVSD or a reduced ejection fraction of <40% as well as for HF.

HF005 (based on NM171)

HF005 Rationale

The aim of this indicator is to encourage practices to confirm diagnoses of heart failure and establish the underlying causes.

Symptoms and signs suggestive of heart failure are not sufficient to make a definitive diagnosis and further investigation is required to confirm cardiac dysfunction and to identify causes. The NICE guideline for chronic heart failure[13] recommends that the results of NT-proBNP tests should be used to determine whether people with suspected heart failure should be referred onwards. People with raised NT-proBNP should have echocardiography and specialist assessment within 6 weeks, but for those with very high levels this should be done more urgently, within 2 weeks. The NICE guideline for acute heart failure[14] recommends that people with new suspected acute heart failure who have raised natriuretic peptides should have echocardiography within 48 hours of admission to hospital.

HF005 Reporting and verification

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

HF003 (NICE 2019 menu ID: NM172)

HF003 Rationale

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

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

NICE NG106 recommends ACE-I is used as first-line therapy in all patients with HF with reduced ejection fraction usually defined as LVSD and that ARBs are used only in patients who are intolerant of ACE-I.

HF003 Reporting and verification

See indicator wording for requirement criteria.

HF006 (NICE 2019 menu ID: NM173)

HF006 Rationale

The NICE guideline for chronic heart failure[15] recommends that beta-blockers licensed for HF are used as first-line therapy in all patients with HF with reduced ejection fraction usually defined as LVSD. It also recommends that treatment with beta-blockers is not withheld solely because of age or the presence of peripheral

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[13] NICE NG106 (2018) Chronic heart failure in adults. https://www.nice.org.uk/guidance/ng106
[14] NICE CG187 (2014, updated 2021) Acute heart failure. https://www.nice.org.uk/guidance/cg187
[15] NICE NG106 (2018) Chronic heart failure. https://www.nice.org.uk/guidance/ng106

vascular disease (PVD), erectile dysfunction (ED), DM, interstitial pulmonary disease and COPD without reversibility. The only co-morbidities with a clear contra-indication to beta-blocker use are those with asthma and reversible airways obstruction (these groups were excluded from clinical trials).

The British National Formulary (BNF) states that "the beta-blockers bisoprolol and carvedilol are of value in any grade of stable HF and LVSD; nebivolol is licensed for stable mild to moderate HF in patients aged over 70, beta-blocker treatment should be initiated at a very low dose and titrated very slowly over a period of weeks or months by those experienced in the management of HF. Symptoms may deteriorate initially, calling for adjustment of concomitant therapy"[16].

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

HF006 Reporting and verification

See indicator wording for requirement criteria.

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

HF007 (based on NM174)

HF007 Rationale

Regular review is associated with improvement in quality of life and a reduction in the need for urgent hospitalisation. NICE guideline NG106 recommends short monitoring intervals (days to 2 weeks) if the clinical condition or medication has changed and 6-monthly for people with stable heart failure.

HF007 Reporting and verification

See indicator wording for requirement criteria.

Hypertension (HYP)

Indicator	Points	Thresholds
Records		
HYP001. The contractor establishes and maintains a register of patients with established hypertension	6	N/A
Ongoing management		

[16] BNF. http://www.evidence.nhs.uk/formulary/bnf/current

HYP003. The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less	14	40-77%
HYP007. The percentage of patients aged 80 years and over with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	5	40-80%

HYP001

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

HYP001 Rationale

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

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

NICE NG136[17] uses the following definitions:

Stage 1 hypertension

Clinic blood pressure ranging from 140/90 mmHg to 159/99 mmHg and subsequent ambulatory blood pressure monitoring (ABPM) daytime average or home blood pressure monitoring (HBPM) average blood pressure ranging from 135/85 mmHg to 149/94 mmHg

Stage 2 hypertension

Clinic blood pressure of 160/100 mmHg or higher but less than 180/120 mmHg and subsequent ABPM daytime average or HBPM average blood pressure of 150/95 mmHg or higher.

Stage 3 or severe hypertension

Clinic systolic blood pressure of 180 mmHg or higher or clinic diastolic blood pressure of 120 mmHg or higher.

If clinic blood pressure reading is between 140/90 mmHg and 180/120 mmHg the NICE guideline for hypertension recommends offering ABPM to confirm a diagnosis of hypertension. If ABPM is unsuitable or the person is unable to tolerate it HBPM is a suitable alternative to confirm a diagnosis of hypertension.

[17] NICE NG136 (2019) Hypertension in adults. https://www.nice.org.uk/guidance/ng136

For patients aged 39 or under, NICE recommend that practitioners consider seeking specialist evaluation of secondary causes of hypertension.

HYP001 Reporting and verification

See indicator wording for requirement criteria.

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

HYP003 (NICE 2012 menu ID: NM53)

HYP003 Rationale

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

HYP003 Reporting and verification

See indicator wording for requirement criteria.

HYP007 (NICE 2012 menu ID: NM54)

HYP007 Rationale

The NICE guideline for hypertension[18] recommends that patients aged 80 years and over with hypertension should be treated to a target blood pressure below 150/90 mmHg. It also recommends that this group of patients should be offered the same antihypertensive drug treatment as people aged 55-80 years, taking into account any co-morbidities.

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

HYP007 Reporting and verification

See indicator wording for requirement criteria.

Peripheral arterial disease (PAD)

Indicator	Points	Thresholds
Records		
PAD001. The contractor establishes and maintains a register of patients with peripheral arterial disease	2	N/A

[18] NICE NG136 (2019) Hypertension in adults. http://www.nice.org.uk/guidance/ng136

PAD – rationale for inclusion of indicator set

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

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

Further information:

- NICE CG147 (2012, updated 2020). Peripheral arterial disease. https://www.nice.org.uk/guidance/cg147

PAD001 (NICE 2011 menu ID: NM32)

PAD001 Rationale

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

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

PAD001 Reporting and verification

See indicator wording for requirement criteria.

Stroke and TIA (STIA)

Indicator	Points	Thresholds
Records		
STIA001. The contractor establishes and maintains a register of patients with stroke or TIA	2	N/A
Ongoing management		
STIA007. The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 12 months that an anti-platelet agent, or an anti-coagulant is being taken	4	57–97%

STIA010. The percentage of patients aged 79 years or less with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less	3	40-73%
STIA011. The percentage of patients aged 80 years and over with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	2	46-86%

STIA – rationale for inclusion of indicator set

Stroke is the third most common cause of death in the developed world. One quarter of stroke deaths occur under the age of 65. There is evidence that appropriate diagnosis and management can improve outcomes[19].

STIA001

STIA001 Rationale

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

It is up to the contractor to decide, on clinical grounds, when to include a patient on the register 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.

STIA001 Reporting and verification

See indicator wording for requirement criteria.

STIA007 (NICE 2015 menu ID: NM94)

STIA007 Rationale

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

The British National Formulary (BNF)[20] makes the following recommendations:

[19] NICE NG128 (2019) Stroke and transient ischaemic attack in over 16s http://www.nice.org.uk/guidance/ng128
[20] BNF stroke treatment summary. https://bnf.nice.org.uk/treatment-summary/stroke.html

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

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

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

Further information - NICE TA210 (201) Clopidogrel and modified-release dipyridamole for the prevention of occlusive vascular events.
http://www.nice.org.uk/guidance/TA210

STIA007 Reporting and verification

See indicator wording for requirement criteria.

STIA010 (NICE 2013 menu ID: NM69)

STIA010 Rationale

This indicator measures the intermediate outcome of a blood pressure of 140/90 mmHg or less in people aged 79 years and under who have experienced a stroke or TIA. It aims to promote the secondary prevention of cardiovascular disease through satisfactory blood pressure control. The intermediate outcome can be achieved through lifestyle advice or drug therapy subject to the caveat below.

The NICE guideline on hypertension[21] recommends drug therapy in people aged 79 years and under with stage 1 hypertension and cardiovascular disease. Antihypertensive drug treatment is recommended for people of any age with stage 2 hypertension.

STIA010 Reporting and verification

See indicator wording for requirement criteria.

STIA011 (NICE 2019 menu ID: NM192)

STIA011 Rationale

This indicator measures the intermediate outcome of a blood pressure of 150/90 mmHg or less in people aged 80 years and over with a history of stroke or TIA. The

[21] NICE NG 136. Hypertension in adults : diagnosis and management. 2019.
https://www.nice.org.uk/guidance/ng136

aim of treating people to this target is to promote secondary prevention of vascular events through satisfactory blood pressure control.

STIA011 Reporting and verification

See indicator wording for requirement criteria.

Diabetes mellitus (DM)

Indicator	Points	Thresholds
Records		
DM017. The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed	6	N/A
Ongoing management		
DM006. The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs)	3	57–97%
DM012. The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 12 months	4	50–90%
DM014. The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register	11	40–90%
DM019. The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less	10	38-78%
DM020. The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months	17	35-75%

DM021. The percentage of patients with diabetes, on the register, with moderate or severe frailty in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months	10	52-92%
DM022. The percentage of patients with diabetes aged 40 years and over, with no history of cardiovascular disease and without moderate or severe frailty, who are currently treated with a statin (excluding patients with type 2 diabetes and a CVD risk score of <10% recorded in the preceding 3 years)	4	50-90%
DM023. The percentage of patients with diabetes and a history of cardiovascular disease (excluding haemorrhagic stroke) who are currently treated with a statin	2	50-90%

DM – rationale for inclusion of indicator set

Diabetes mellitus (DM) is one of the common endocrine diseases affecting all age groups with approximately 3.5 million people in the England having the condition. Effective control and monitoring can reduce mortality and morbidity. Much of the management and monitoring of diabetes, particularly type 2 diabetes, is undertaken by the GP and members of the primary care team.

Further information:

- NICE NG28 (2015, updated 2021) Type 2 diabetes in adults. http://www.nice.org.uk/guidance/NG28
- NICE NG19 (2015, updated 2019). Diabetic foot problems. http://www.nice.org.uk/guidance/NG19/
- NICE NG18 (2015, updated 2020). Diabetes (type 1 and type 2) in children and young people. http://www.nice.org.uk/guidance/NG18
- NICE NG17 (2015, updated 2021). Type 1 diabetes in adults. http://www.nice.org.uk/guidance/NG17

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 these items, but it is the contractor's responsibility to ensure that they have been done.

DM017 (NICE 2017 menu ID: NM41)

DM017 Rationale

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

diagnosis of diabetes in primary care in England[22]. The summary findings of the report included an algorithm to provide guidance to healthcare professionals on making a new diagnosis of diabetes. In line with this report, the diabetes register indicator includes all types of diabetes within the proposed algorithm. Women with gestational diabetes are excluded from this indicator set.

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

This indicator does not specify how the diagnosis is made and a record of the diagnosis will, for the purposes of the QOF, be regarded as sufficient evidence of diabetes. However, there are a substantial number of patients with diabetes who remain undiagnosed and, 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[23] states that fasting plasma glucose ≥7.0 mmol/l (126 mg/dl) or 2-h plasma glucose ≥11.1 mmol/l (200 mg/dl) is used as criteria for diagnosing diabetes.

In 2011 an addendum to the 2006 WHO diagnostic criteria was published to allow the use of glycated haemoglobin (HbA1c) in diagnosing DM[24]. The addendum does not invalidate the 2006 recommendations on the use of plasma glucose measurements to diagnose diabetes. The WHO recommend that HbA1c can be used as a diagnostic test for diabetes, provided that stringent quality assurance tests are in place and assays are standardised to criteria aligned to the international reference values and there are no conditions present that preclude its accurate measurement. An HbA1c of 48 mmol/mol (6.5 per cent) is recommended as the cut-off point for diagnosing diabetes. A value less than 48 mmol/mol (6.5 per cent) does not exclude diabetes diagnosed using glucose tests.

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

The WHO also recommends that the diagnosis of diabetes in an asymptomatic patient is not made on the basis of a single abnormal plasma glucose or HbA1c value. At least one additional HbA1c or plasma glucose test result with a value in the

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[22] RCGP and NHS Diabetes. Coding, classification and diagnosis of diabetes. 2011. https://clininf.eu/wp-content/uploads/2017/02/nhs_diabetes_and_rcgp_cod_final_report.pdf
[23] WHO. Definition and diagnosis of DM and intermediate hyperglycaemia. 2006. www.who.int/diabetes/publications/Definition%20and%20diagnosis%20of%20diabetes_new.pdf
[24] WHO. Use of HbA1c in the diagnosis of DM. Abbreviated report of a WHO consultation. 2011. www.who.int/diabetes/publications/report-hba1c_2011.pdf

diabetic range is required, either fasting, from a random (casual) sample, or from an oral glucose tolerance test (OGTT).

The Business Rules include a clinical code for “diabetes in remission”. This refers to maintenance of non-diabetic glycaemic levels off all glucose-lowering medication. For type 2 diabetes, this may be achieved through lifestyle interventions or bariatric surgery. However, people with remission of diabetes may still experience the macrovascular and microvascular complications of diabetes and therefore need continued monitoring.

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

DM017 Reporting and verification

See indicator wording for requirement criteria.

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

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

DM006 (NICE 2015 menu ID: NM95)

DM006 Rationale

NICE guidelines[25],[26] recommend the use of ACE-I (or ARBs) to slow the progression of renal disease in patients with diabetes with urine albumin: creatinine ratio (ACR) ≥3 mg/mmol. Trial evidence suggests that these are most effective when given in the maximum dose quoted in the BNF.

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

DM006 Reporting and verification

See indicator wording for requirement criteria.

DM012 (NICE 2010 menu ID: NM13)

DM012 Rationale

[25] NICE NG17 (2015, updated 2021) Type 1 diabetes in adults. https://www.nice.org.uk/guidance/ng17
[26] NICE NG28 (2015, updated 2021). Type 2 diabetes in adults. https://www.nice.org.uk/guidance/ng28

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

The NICE guideline on diabetic foot problems[27] outlines foot risk classification and recommends at least annual reassessment.

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

DM012 Reporting and verification

See indicator wording for requirement criteria.

DM014 (NICE 2011 menu ID: NM27)

DM014 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. Structured education programmes are supported by NICE guidance[28,29].

The indicator requires that SE is offered to every person with diabetes and/or their carer from the time of diagnosis. An alternative education programme of equal standard may be offered to people unable or unwilling to participate in group education sessions.

There are several accredited digital education programmes including nationally commissioned services which are available to all GPs to refer in to. Healthy Living is a programme for people living with type 2 diabetes and their carers, and My Type 1 is for people living with type 1 diabetes. Referral to these programmes will also meet the criteria for this indicator. These programmes are also available to people who have been diagnosed within any timeframe, supporting annual reinforcement.

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

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[27] NICE NG19 (2015, updated 2019) Diabetic foot problems: prevention and management. http://www.nice.org.uk/guidance/NG19/

[28] NICE NG17 (2015, updated 2021) Type 1 diabetes in adults. https://www.nice.org.uk/guidance/ng17

[29] NICE NG28 (2015, updated 2021). Type 2 diabetes in adults. https://www.nice.org.uk/guidance/ng28

differing expectations for referral into SE programmes from diagnosis for people with type 1 and type 2 diabetes.

DM014 Reporting and verification

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

DM019 (NICE 2018 menu ID: NM159)

DM019 Rationale

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

Applying universal BP targets to all people with diabetes may inadvertently lead to the potential for undertreatment in those with less complex need and overtreatment in those with complex needs and co-morbidity[30]. This indicator focuses upon blood pressure management in people with diabetes without moderate or severe frailty and thus aims to reduce potential undertreatment and support better control of biomedical targets in people with the greatest capacity to benefit.

Contractors should note that the BP target in this indicator is higher than that recommended for patients with Type 1 diabetes in NG17, where they should be aiming for 135/85mmHg or 130/80mmHg if the person has albuminuria or two or more features of metabolic syndrome. Contractors should use their clinical judgement when setting individual blood pressure targets, particularly for people with advanced age, living with frailty or multimorbidity.

DM019 Reporting and verification

See indicator wording for requirement criteria.

DM020 (NICE 2018 menu ID: NM157)

DM020 Rationale

Glycated haemoglobin (HbA1c) is commonly used to monitor glucose control as it provides a measure of average glycaemia over the preceding 8-12 weeks. Rising levels of HbA1c increase the risk of mortality and developing macrovascular and microvascular complications. However, applying universal target levels regardless of comorbidities may inadvertently lead to over-treatment, especially in older people with type 2 diabetes and people living with frailty.[31] This indicator allows for an individualised management approach that adjusts care according to an individual's frailty status. It aims to enable patients without moderate or severe frailty to benefit from tighter glycaemic control. Whilst the target in this indicator is higher than those

[30] Kearney et al. Overtreatment and undertreatment: time to challenge our thinking. BJGP. 2019;67(633):442-443.
[31] Strain et al. Type 2 diabetes mellitus in older people: a brief statement of key principles of modern day management including the assessment of frailty. Diabetic medicine. 2018;35(7): 838-845.

presented in NICE guidelines[32, 33], this has been pragmatically selected as it represents the point at which people with type 2 diabetes should be considered for treatment intensification.

DM020 Reporting and verification

See indicator wording for requirement criteria.

DM021 (NICE 2018 menu ID: NM158)

DM021 Rationale

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

DM021 Reporting and verification

See indicator wording for requirement criteria.

DM022 (NICE 2018 menu ID: NM162)

DM022 Rationale

Cardiovascular risk is elevated in people with type 1 and type 2 diabetes. The NICE guideline for cardiovascular disease risk assessment and lipid modification[34] recommends that people with type 1 diabetes are offered statin treatment for primary prevention when they are older than 40 years, or they have had diabetes for more than 10 years, or they have established nephropathy or other CVD risk factors. It also recommends that people with type 2 diabetes should be offered statin therapy if they have a 10% or greater 10-year risk of developing CVD, estimated using the QRISK2 assessment tool. The Business Rules for this indicator include clinical codes for QRISK, QRISK2, QRISK3, Framingham and Joint British Societies risk score.

In September 2016, the NICE guideline for cardiovascular risk assessment and lipid modification was amended and reinforced its recommendation of high-intensity statin

[32] NICE NG17 (2015, updated 2021) Type 1 diabetes in adults. http://www.nice.org.uk/guidance/NG17
[33] NICE NG28 (2015, updated 2021) Type 2 diabetes in adults. www.nice.org.uk/guidance/NG28
[34] NICE CG181 (2014, updated 2016) Cardiovascular disease: risk assessment and reduction, including lipid modification. https://www.nice.org.uk/guidance/cg181

treatment, for primary prevention (atorvastatin 20mg) and secondary prevention (atorvastatin 80mg).

DM022 Reporting and verification

See indicator wording for requirement criteria.

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

DM023 (NICE 2018 menu ID: NM163)

DM023 Rationale

The NICE guideline for cardiovascular disease risk assessment and lipid modification[35] recommends that high intensity statin therapy be considered for the secondary prevention of CVD. Statin therapy helps to lower levels of low-density lipoprotein (LDL) cholesterol and is associated with a reduction in MI, coronary heart disease and stroke. Treatment should start with atorvastatin 80mg, however there are situations in which a lower dose or alternative high statin should be used. This indicator wording allows for the selection of an appropriate and individualised dosage.

DM023 Reporting and verification

See indicator wording for requirement criteria.

Asthma (AST)

Indicator	Points	Thresholds
Records		
AST005. The contractor establishes and maintains a register of patients with asthma aged 6 years or over, excluding patients with asthma who have been prescribed no asthma related drugs in the preceding 12 months	4	N/A
Initial diagnosis		

[35] NICE CG181 (2014, updated 2016) Cardiovascular disease: risk assessment and reduction, including lipid modification. https://www.nice.org.uk/guidance/cg181

AST006. The percentage of patients with a diagnosis of asthma on or from 1 April 2021 with either: 1. A record of spirometry and one other objective test (FeNO or reversibility or variability) between 3 months before and 6 months after diagnosis; or 2. If newly registered in the preceding 12 months with a diagnosis of asthma recorded on or after 1 April 2021 but no record of objective tests being performed at the date of registration, with a record of spirometry and one other objective test (FeNO or reversibility or variability) recorded within 6 months of registration	15	45–80%
Ongoing management		
AST007. The percentage of patients with asthma on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using a validated asthma control questionnaire, a recording of the number of exacerbations, an assessment of inhaler technique and a written personalised action plan	20	45–70%
AST008. The percentage of patients with asthma on the register aged 19 or under, in whom there is a record of either personal smoking status or exposure to second-hand smoke in the preceding 12 months	6	45–80%

AST – rationale for inclusion of indicator set

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

AST005 (based on NM165)

AST005 Rationale

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

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 inflammation, limitation and reversibility. Obstructive airways disease produces a decrease in peak expiratory flow (PEF) and forced expiratory volume in one second (FEV_1) but which may resolve 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. Asthmatic inflammation of the airways

produces higher levels of the fraction of exhaled nitric oxide (FeNO), which can be measured using a point of care test. If lung function and FeNO are repeatedly normal in the presence of symptoms, then the diagnosis of asthma is in doubt.

Children

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

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

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

- Presence of key features in the history and examination
- Careful consideration of alternative diagnoses.

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.

Further information - SIGN guideline 158. SIGN and BTS. British guideline on the management of asthma. 2016[36]. NICE guideline NG80: Asthma: diagnosis, monitoring and chronic asthma management[37].

AST005 Reporting and verification

See indicator wording for requirement criteria.

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

Patients with asthma whose sole asthma medication is one associated with COPD will no longer appear on the QOF asthma register. Patients receiving additional, appropriate asthma treatment such as short-acting bronchodilators or steroid

[36] https://www.sign.ac.uk/our-guidelines/british-guideline-on-the-management-of-asthma/
[37] NICE NG80 (2017, updated 2021) Asthma. https://www.nice.org.uk/Guidance/NG80

inhalers will remain on the register. Practices may wish to review the records of any patients affected by this change to review their asthma treatment however, a change in prescribing should only be done where clinically appropriate.

AST006 (based on NM166)

AST006 Rationale

The aim of this indicator is to encourage use of objective tests to confirm asthma diagnosis, and subsequently improve accuracy of diagnosis and reduce incidences of patients receiving inappropriate care. This will mean that some patients may require referral for the necessary diagnostic tests to be completed following locally commissioned pathways. Results of testing should inform subsequent treatment for people with asthma and lead to improved health and wellbeing.

Spirometry is the key investigation for distinguishing obstructive and restrictive respiratory conditions and will determine subsequent investigations[38]. It is crucial that diagnostic spirometry is performed to published quality standards[39,40] and therefore referral to a specialist service may be required.

Adults (aged 17 and over) should be diagnosed, if they have symptoms suggestive of asthma and:

- A FeNO level of 40 parts per billion (ppb) or more with either positive bronchodilator reversibility or positive peak flow variability or bronchial hyperreactivity, or
- A FeNO level between 25 and 39 ppb and a positive bronchial challenge test, or
- Positive bronchodilator reversibility and positive peak flow variability irrespective of FeNO level.[41]

Referral may be required for FeNO testing and for challenge testing to measure bronchial hyperreactivity, which is a hallmark of asthma. The bronchial challenge test involves breathing in gradually increasing doses of a medication, such as methacholine or mannitol, whilst measuring the FEV_1.

If an adult, young person or child with symptoms suggestive of asthma cannot perform a particular test, try to perform at least 2 other objective tests. Diagnose suspected asthma based on symptoms and any positive objective test results.

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

[40] Association for respiratory technology and physiology. A guide to performing quality assured diagnostic spirometry. http://www.artp.org.uk/

[41] NICE NG80 (2017, updated 2021) Asthma. https://www.nice.org.uk/Guidance/NG80

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

If another diagnosis is more likely

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

Co-morbidity: asthma and COPD

A proportion of patients with asthma will have both asthma and COPD e.g. they have airway obstruction that does not reverse to normal but also have substantial reversibility[42].

AST006 Reporting and verification

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

AST007 (based on NM167)

AST007 Rationale

This indicator aims to encourage the use of validated asthma questionnaires, recording of the number of exacerbations, and written action plans in annual asthma reviews. These reviews can help identify people at increased risk of poor outcomes and allow them to use information from their review to self-manage their asthma and maximise their future health.

The BTS/SIGN clinical guideline[43] proposes a structured system for recording inhaler technique, morbidity, PEF levels, current treatment and asthma action plans.

QOF explicitly requires an assessment of asthma control using a validated asthma control questionnaire using the Asthma Control Questionnaire[44] or Asthma Control Test[45], a recording of the number of exacerbations, an assessment of inhaler technique and a written personalised action plan.

If the asthma appears to be uncontrolled, take in account the possible reasons below before adjusting medicines:

- Alternative diagnoses
- Smoking (active or passive)

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[42] NICE NG115 (2018, updated 2019) Chronic obstructive pulmonary disease in over 16s. https://www.nice.org.uk/guidance/NG115
[43] BTS/SIGN clinical guideline 158. Management of asthma. 2019. https://www.sign.ac.uk/our-guidelines/british-guideline-on-the-management-of-asthma/
[44] https://www.qoltech.co.uk/acq.html
[45] https://www.asthma.com/additional-resources/asthma-control-test.html

- Poor inhaler technique
- Lack of adherence
- Occupation exposures
- Psychosocial factors
- Seasonal or environmental factors.

For more information on asthma management and recommendations made to prevent deaths from asthma in the future, see the National Review of Asthma Deaths (NRAD) [46]

AST007 Reporting and verification

See indicator wording for requirement criteria.

The Business Rules require that contractors code the review and the assessment of asthma control using the Asthma Control Questionnaire or the Asthma Control Test, the number of exacerbations in the month before the asthma review and the provision of a written personalised asthma plan recorded on the same day as the asthma review in order to meet the requirements of this indicator.

AST008 (based on NM168)

AST008 Rationale

There are very few studies that have considered the question of whether smoking affects asthma severity[47]. 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[48]. NICE guidance recommends taking smoking status (active or passive) into account before starting or adjusting medicines for asthma[49].

This indicator aims to encourage general practice to ask children and young people aged 6 to 19 years with asthma about their exposure to tobacco and second-hand smoke. Support can then be offered to patients and the people they live with to understand the risks of smoking and exposure to second-hand smoke for those with asthma, and how to access smoking cessation services.

AST008 Reporting and verification

See indicator wording for requirement criteria.

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[46] https://www.rcplondon.ac.uk/projects/national-review-asthma-deaths
[47] https://erj.ersjournals.com/content/41/3/716
[48] Price et al. ClinExp Allergy 2005; 35: 282-287
[49] NICE NG80 (2017, updated 2021) Asthma. https://www.nice.org.uk/Guidance/NG80

Chronic obstructive pulmonary disease (COPD)

Indicator	Points	Thresholds
Records		
COPD009. The contractor establishes and maintains a register of: 1. Patients with a clinical diagnosis of COPD before 1 April 2021 and 2. Patients with a clinical diagnosis of COPD on or after 1 April 2021 whose diagnosis has been confirmed by a quality assured post bronchodilator spirometry FEV_1/FVC ratio below 0.7 between 3 months before or 6 months after diagnosis (or if newly registered in the preceding 12 months a record of an FEV_1/FVC ratio below 0.7 recorded within 6 months of registration); and 3. Patients with a clinical diagnosis of COPD on or after 1 April 2021 who are unable to undertake spirometry	8	N/A
Ongoing management		
COPD010. The percentage of patients with COPD on the register, who have had a review in the preceding 12 months, including a record of the number of exacerbations and an assessment of breathlessness using the Medical Research Council dyspnoea scale	9	50–90%
COPD008. The percentage of patients with COPD and Medical Research Council (MRC) dyspnoea scale ≥3 at any time in the preceding 12 months, with a subsequent record of an offer of referral to a pulmonary rehabilitation programme (excluding those who have previously attended a pulmonary rehabilitation programme)	2	40-90%

COPD – rationale for inclusion of indicator set

Chronic obstructive pulmonary disease (COPD) describes a group of lung conditions that cause obstructive airways disease and includes chronic bronchitis and emphysema. COPD is a common disabling condition responsible for significant unscheduled healthcare utilisation. When applicable, the most effective intervention is smoking cessation. Pulmonary rehabilitation has been shown to produce an improvement in quality of life and decrease exacerbations. Inhaled bronchodilators and, in some cases, inhaled corticosteroids can be of benefit.

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.

COPD009 (based on NM169)

COPD009 Rationale

The aim of this indicator is to encourage practices to maintain a register of patients with a diagnosis of COPD and to use that register of patients to inform the care they deliver, including objective testing to support diagnosis of COPD as recommended in NICE guidance NG115: Chronic obstructive pulmonary disease in over 16s: diagnosis and management[50]. Linking diagnosis and objective testing to entry onto the QOF COPD disease register aims to contribute towards a reduction in both misdiagnosis and the risk of overtreatment in people with COPD. Referral to a specialist service may be appropriate for objective testing and to make an accurate diagnosis.

COPD009 Reporting and verification

See indicator wording for requirement criteria. Patients with clinical diagnoses of COPD and no record of objective tests will not be excluded from the register but the expectation is that, over time, the proportion of patients with spirometry confirming fixed airflow obstruction will increase relative to those without spirometry recorded.

Where patients have co-existing COPD and asthma they will be included on both disease registers.

COPD0010 (NICE 2019 menu ID: NM170)

COPD0010 Rationale

This indicator aims to encourage the use of recording of number of exacerbations and assessments of breathlessness in annual COPD reviews and is supported by NICE guidance. Understanding the frequency of exacerbations can help when creating personalized management plans, identifying triggers and avoiding future exacerbations.

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

- Number of exacerbations
- The degree of breathlessness (Medical Research Council [MRC] dyspnoea scale).

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

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[50]NICE NG115 (2018, updated 2019) Chronic obstructive pulmonary disease in over 16s. https://www.nice.org.uk/guidance/ng115

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

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

COPD0010 Reporting and verification

See indicator wording for requirement criteria.

COPD008 (NICE 2012 menu ID: NM47)

COPD008 Rationale

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

The NICE guideline for COPD[51] recommends that pulmonary rehabilitation should be offered to all patients who consider themselves to be functionally disabled due to their COPD (usually MRC dyspnoea scale score of ≥3). Whilst most patients are likely to benefit, a rehabilitation programme is not suitable for patients who are unable to walk, have unstable angina or who have recently had a myocardial infarction.

Medical management should be optimised before referral.

COPD008 Reporting and verification

See indicator wording for requirement criteria.

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

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

Dementia (DEM)

Indicator	Points	Thresholds
Records		
DEM001. The contractor establishes and maintains a register of patients diagnosed with dementia	5	N/A

[51] NICE NG115 (2018, updated 2019) Chronic obstructive pulmonary disease in over 16s. https://www.nice.org.uk/guidance/NG115

Ongoing management		
DEM004. The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months	39	35–70%

DEM – rationale for inclusion of indicator set

Dementia is a syndrome characterised by an insidious but ultimately catastrophic progressive global deterioration in intellectual function and is a main cause of late-life disability. The prevalence of dementia increases with age and is estimated to be approximately seven per cent in those over 65. Alzheimer's disease accounts for around 50 to 75 per cent of cases of dementia with vascular dementia accounting for up to 20 per cent[52].

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.

DEM001

DEM001 Rationale

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

DEM001 Reporting and verification

See indicator wording for requirement criteria.

DEM004 (NICE 2015 menu ID: NM107)

DEM004 Rationale

The NICE guideline for dementia[53] recommends agreeing care plans with health and social services for people who have dementia, and having formal reviews at agreed frequencies

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

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[52] Alzheimer's Society (2020) Alzheimer's Society's view on demography. https://www.alzheimers.org.uk/about-us/policy-and-influencing/what-we-think/demography
[53] NICE NG97 (2018) Dementia. https://www.nice.org.uk/guidance/ng97

The face-to-face care plan or advanced care plan review focuses on support needs of the patient and their carer. Regular review can help ensure that any changes in need can be addressed. In particular the review should address the following key issues (in line with the D.E.M.E.N.T.I.A framework set out in NHS England's Dementia: Good personalised care and support planning guide):

- An appropriate physical, mental health and social review,
- A medication review, with particular attention to antipsychotic medication in consideration of:
- Side effects such as risk of diabetes and dyslipidaemia; and
- Anticholinergic effects in line with NICE guidance [NG97],
- A record of the patients' wishes for the future,
- Communication and co-ordination arrangements with secondary care (if applicable),
- Identification of the patients' carer(s); and

1. Obtain appropriate permissions to authorise the practice to speak directly to the nominated carer(s) and provide details of support services available to the patient and their family, if applicable, the carer's needs for information commensurate with the stage of the illness and his or her and the patient's health and social care needs,
2. As appropriate, the carer should be included in the care plan or advanced care plan discussions,
3. If applicable, the impact of caring on the care-giver,
4. Offer the carer a health check[54] to address any physical and mental health impacts, including signposting to any other relevant services to support their health and wellbeing.

The practice will agree with the patient and their carer, what is to be covered in the review and the duration of the consultation - where appropriate, extended consultations may take up to 30 minutes[55]. Ideally the first such appointment would be within six months of diagnosis.

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

- Concurrent physical conditions (e.g. joint pain or inter-current infections)

[54] Where the carer is registered at a different practice, the patients practice should inform the patient's carer that they can seek advice from their own practice.
[55] The practice should agree with the patient the most suitable length of this for this appointment, this could be provided as two 15 minute appointments if this is more appropriate for the patient.

- 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[56].

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[57]. As the illness progresses, needs may change, and the review may focus more on issues such as respite care.

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

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

Further information

- NICE NG97 (2018) Dementia. https://www.nice.org.uk/guidance/ng97
- NICE QS184 (2019) Dementia. https://www.nice.org.uk/guidance/qs184
- Forget me not dementia training. http://www.forgetmenotdementia.co.uk/
- NSF for Older People. 2001. http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_4003066
- NICE PH16 (2008) Mental wellbeing in over 65s: occupational therapy and physical activity interventions. https://www.nice.org.uk/guidance/ph16
- NHS Choices. Looking after someone with dementia. 2015. https://www.nhs.uk/conditions/dementia/carers/

DEM004 Reporting and verification

[56] Alzheimer's society: Apathy, anxiety and depression. 2017
[57] Eccles et al. BMJ 1998; 317: 802-808

See indicator wording for requirement criteria.

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

Depression (DEP)

Indicator	Points	Thresholds
Initial management		
DEP003.The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis	10	45–80%

DEP – rationale for inclusion of the indicator set

Depression is common and disabling.

The Adult Psychiatric Morbidity Survey, 2014[58] estimated prevalence for a depressive episode among people aged 16 in England was 3.3 per cent. If the broader and less specific category of mixed depression and anxiety ('common mental health disorder – not otherwise stated') is included, these figures increase dramatically to 7.8 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[59]. Major depressive disorder is increasingly seen as chronic and relapsing, resulting in high levels of personal disability, lost quality of life for patients, their family and carers, multiple morbidity, suicide, higher levels of service use and many associated economic costs. In 2007, the total cost of depression in England was reported to be £7.5 billion of which health service costs comprised £1.7 billion and lost earnings £5.8 billion. When the cost of informal care, lower productivity and other public sector costs are included this figure is estimated at between £20.2-23.8 billion a year[60].

DEP003 (based on NICE 2012 menu ID: NM50)

DEP003 Rationale

The NICE guideline on depression in adults[61] states that patients with mild

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[58] https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014

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

[60] DH. No health without mental health – supporting document. 2011. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

[61] NICE CG90 (2009 updated 2018) Depression in adults: recognition and management. https://www.nice.org.uk/guidance/CG90

depression or sub-threshold symptoms be reviewed and re-assessed after initial presentation, normally within two weeks.

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

When assessing a person who may have depression, conduct a comprehensive assessment that does not rely simply on a symptom count. Take into account both the degree of functional impairment and/or disability associated with the possible depression and the duration of the episode.

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

DEP003 Reporting and verification

See indicator wording for requirement criteria.

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

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

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

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

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

Mental health (MH)

Indicator	Points	Thresholds
Records		
MH001. The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy	4	N/A
Ongoing management		
MH002. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate	6	40–90%
MH003. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months	4	50–90%
MH006. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months	4	50-90%
MH007. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months	4	50-90%
MH011. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of a lipid profile in the preceding 12 months (in those patients currently prescribed antipsychotics, and/or have pre-existing cardiovascular conditions, and/or smoke, and/or are overweight (BMI of ≥23 kg/m2 or ≥25 kg/m2 if ethnicity is recorded as White)) or preceding 24 months for all other patients	8	50-90%
MH012. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months	8	50-90%

MH – rationale for inclusion of indicator set

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

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

This indicator set focuses on patients with severe mental illness (SMI). There are separate indicator sets that focus on patients with depression and dementia.

NICE CG178[62] recommends primary care utilise registers to monitor the physical health of patients with psychosis or schizophrenia.

NICE CG185[63] recommends that patients with bipolar affective disorder have a physical health review, normally in primary care, performed at least annually, including the following health checks:

- Weight or BMI, diet, nutritional status and level of physical activity
- Cardiovascular status, including pulse and blood pressure
- Metabolic status, including glycosylated haemoglobin (HbA1c) and blood lipid profile
- Liver function
- Renal and thyroid function, and calcium levels, for people taking long-term lithium.

QOF rewards practices for delivering all six elements of the comprehensive annual physical health check for patients with schizophrenia, bipolar affective disorder and other psychoses as defined in the NHS Long Term Plan.

In addition to smoking, poor diet and lack of exercise, antipsychotic drugs vary in their liability for metabolic side effects such as weight gain, lipid abnormalities and disturbance of glucose regulation. Specifically, they increase the risk of the metabolic syndrome, a recognised cluster of features (hypertension, central obesity, glucose intolerance or insulin resistance or dyslipidaemia) which is a predictor of type 2 diabetes and CHD[64].

Due to the combination of lifestyle factors and side effects of anti-psychotic medication, there is a high incidence of cardiovascular disease (CVD) causing premature death in people with SMI (15 years for bipolar disorder and 25 years for schizophrenia). The aim of the comprehensive annual physical health check is to identify and address risk factors for CVD.

Further information

- NICE CG178 (2014) Psychosis and schizophrenia in adults. https://www.nice.org.uk/guidance/cg178

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[62] NICE CG178 (2014) Psychosis and schizophrenia in adults. http://www.nice.org.uk/guidance/CG178

[63] NICE CG185 (2014, updated 2020) Bipolar disorder: assessment and management. http://www.nice.org.uk/guidance/CG185

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

- Practices may wish to utilise the Lester tool; a mental health physical review template https://www.tpp-uk.com/mhpr

MH001

MH001 Rationale

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

Patients on lithium therapy are defined as patients with a prescription for lithium within the preceding six months.

Remission from severe 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 severe 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[65] is used.

In the absence of strong evidence of what constitutes 'remission 'from severe 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 subsequent indicators (i.e. they are excluded from the denominator for MH002, MH003, MH006, MH007, MH011 and MH012).

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

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

MH001 Reporting and verification

See indicator wording for requirement criteria.

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

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

MH002 (NICE 2015 menu ID: NM108)

MH002 Rationale

This indicator reflects good professional practice and is supported by NICE CG178[66] and CG185[67].

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

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

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

- Patient's current health status and social care needs including how needs are to be met, by whom and the patient's expectations
- Co-ordination arrangements with secondary care and/or mental health services and a summary of what services are actually being received
- Occupational status – for people being supported by secondary mental health services in England, there is a 65% employment gap compared with the general population[68]. 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[69].

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[66] NICE CG178 (2014). Psychosis and schizophrenia in adults. http://www.nice.org.uk/guidance/CG178
[67] NICE CG185 (2014, updated 2020) Bipolar disorder. https://www.nice.org.uk/guidance/cg185
[68] https://www.longtermplan.nhs.uk/online-version/appendix/health-and-employment/
[69] See Grove and Drurie. Social firms: an instrument for social and economic inclusion. Redhill, Social Firms UK. 1999.

- ‘Early warning signs’ from the patient's perspective that may indicate a possible relapse[70]. Many patients may already be aware of their early warning signs (or relapse signature) but it is important for the primary care team to also be aware of noticeable changes in thoughts, perceptions, feelings and behaviours leading up to their most recent episode of illness as well as any events the patient thinks may have acted as triggers.
- The patient's preferred course of action (discussed when well) in the event of a clinical relapse, including who to contact and wishes around medication.

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

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

MH002 Reporting and verification

See indicator wording for requirement criteria.

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

MH003 (based on NM17)

MH003 Rationale

NICE guidance[71,72] recommends annual monitoring of blood pressure for people with bipolar disorder, psychosis or schizophrenia. Patients with schizophrenia have mortality between two and three times that of the general population and most of the excess deaths are from diseases that are the major causes of death in the general population. A prospective record linkage study of the mortality of a community cohort of 370 patients with schizophrenia found that the increased mortality risk is probably life-long and it suggested that cardiovascular mortality of schizophrenia has increased over the past 25 years relative to the general population[73]. The NICE guideline on bipolar disorder also states that the standardised mortality ratio for cardiovascular death may be twice that of the general population but appears to be reduced if patients adhere to long-term medication.

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[70] Birchwood et al. Advances in Psychiatric Treatment. 2000; 6: 93-101 and Birchwood and Spencer. Clinical Psychology Review. 2001; 21(8): 1211-26
[71] NICE CG178 (2014). Psychosis and schizophrenia in adults. http://www.nice.org.uk/guidance/CG178
[72] NICE CG185 (2014, updated 2020) Bipolar disorder. https://www.nice.org.uk/guidance/cg185
[73] Brown S, Kim M, Mitchell C et al. 25 year mortality of a community cohort with schizophrenia. BJP. 2010. 196: 116-21.

Hypertension in people with schizophrenia is estimated at 19 per cent compared with 15 per cent in the general population[74]. A cross-sectional study of 4310 patients diagnosed with bipolar disorder in 2001 receiving care at veterans 'administration facilities found a prevalence of hypertension of 35 per cent[75].

There is evidence to suggest that physical conditions such as cardiovascular disorders go unrecognised in psychiatric patients. A direct comparison of cardiovascular screening (blood pressure, lipid levels and smoking status) of patients with asthma, patients with schizophrenia and other attendees indicated that general practice were less likely to screen patients with schizophrenia for cardiovascular risk compared with the other two groups[76].

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

MH003 Reporting and verification

See indicator wording for requirement criteria.

MH006 (based on NM16)

MH006 Rationale

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

About 40% of people with schizophrenia are living with obesity which is also common in people with bipolar disorders. NICE Guidelines CG178[77] and CG185[78] recommend annual monitoring of weight or BMI in these patient groups.

MH006 Reporting and verification

See indicator wording for requirement criteria.

MH007 (based on NM15)

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[74] Hennekens C, Hennekens A, Hollar D. Schizophrenia and increased risks of CVD. 2005. Am Heart Journal 150: 1115-21
[75] Kilbourne AM, Cornelius JR, Han X et al. Burden of general medical conditions among individuals with bipolar disorder. 2004. Bipolar Disorder 6: 368-73
[76] Roberts L, Roalfe A, Wilson S et al. Physical health care of patients with schizophrenia in primary care: a comparative study. 2007. FamPract 24: 34-40
[77] NICE CG178 (2014) Psychosis and schizophrenia in adults. http://www.nice.org.uk/guidance/cg178
[78] NICE CG185 (2014, updated 2020) Bipolar disorder. http://www.nice.org.uk/guidance/cg185

MH007 Rationale

Alcohol and other 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[79]. The National Psychiatric Morbidity Survey in England found that 16 per cent of people with schizophrenia were drinking above the lower risk consumption levels (14 units) of alcohol. [80],[81]. Bipolar affective disorder is also highly co-morbid with alcohol and other substance abuse.

MH007 Reporting and verification

See indicator wording for requirement criteria.

MH011 (based on NM129)

MH011 Rationale

NICE guidance[82,83] recommends annual blood lipid profiles for people with bipolar disorder, psychosis or schizophrenia. A 2014 literature review that explored obesity and serious mental ill health, concluded that the use of antipsychotic medication may interfere with the normal processes which regulate food intake and metabolism[84]. Individuals with severe mental illness have five times the risk of dyslipidaemia than the general population[85].

MH011 Reporting and verification

Within the Business Rules currently being prescribed an antipsychotic medication is defined as a prescription in the preceding 6 months; pre-existing cardiovascular conditions are defined as CHD, diabetes, stroke, peripheral arterial disease and chronic kidney disease; being a current smoker is defined as a patient whose notes record smoking status in the preceding 12 months and being overweight is defined as latest BMI of ≥ 23 kg/m2 or ≥25 kg/m2 if ethnicity is recorded as White.

MH012 (based on NM130)

MH012 Rationale

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[79] RCP Research and Training Unit. Banerjee S, Clancy C, Crome I, editors. Co-existing problems of mental disorder and substance misuse (dual diagnosis). 2001. Information manual.
[80] Meltzer H, Gill B, Pettigrew M et al. OCPS Survey of Psychiatric Morbidity in GB. Report 3: Economic activity and social functioning of adults with psychiatric disorders. 1996.
[81] Farrell M, Howes S, Taylor C et al. Substance misuse and psychiatric co-morbidity: an overview of the OCPS National Psychiatric Morbidity Survey. Addictive behaviours 23: 909-18. 1998.
[82] NICE CG178 (2014). Psychosis and schizophrenia in adults. http://www.nice.org.uk/guidance/CG178
[83] NICE CG185 (2014, updated 2020) Bipolar disorder. https://www.nice.org.uk/guidance/cg185
[84] Bradshaw, T., & Mairs, H. (2014, June). Obesity and serious mental ill health: a critical review of the literature. In *Healthcare* (Vol. 2, No. 2, pp. 166-182). Multidisciplinary Digital Publishing Institute.
[85] https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2019/03/nhs-rightcare-toolkit-cvd-prevention.pdf

NICE guidance[86,87] recommends annual monitoring of blood glucose or HbA1c for people with bipolar disorder, psychosis or schizophrenia. Diabetes is 2–3 times more common among people with SMI than the general population[88] and antipsychotic medication can be diabetogenic[89]. The National Diabetes Audit confirms previous studies that type 2 diabetes is twice as common among people with SMI than in the general population. The rates of type 1 diabetes are about the same as the general population, although the overall numbers are small. People with SMI are more likely to develop type 2 diabetes earlier than the general population, frequently in the fourth and fifth decades. People with an SMI are more likely to develop type 1 diabetes later than those without a SMI, as late as the third and fourth decades of life[90].

MH012 Reporting and verification

See indicator wording for requirement criteria.

Patients who have a diagnosis of diabetes will be excluded from this indicator.

Cancer (CAN)

Indicator	Points	Thresholds
Records		
CAN001. The contractor establishes and maintains a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers diagnosed on or after 1 April 2003	5	N/A
Ongoing management		
CAN004. The percentage of patients with cancer, diagnosed within the preceding 24 months, who have a patient Cancer Care Review using a structured template recorded as occurring within 12 months of the date of diagnosis	6	50–90%
CAN005. The percentage of patients with cancer, diagnosed within the preceding 12 months, who have had the opportunity for a discussion and informed of the support available from primary care, within 3 months of diagnosis	2	70-90%

[86] NICE CG178 (2014). Psychosis and schizophrenia in adults. http://www.nice.org.uk/guidance/CG178
[87] NICE CG185 (2014, updated 2020) Bipolar disorder. https://www.nice.org.uk/guidance/cg185
[88] Vinogradova Y, Coupland C, Hippisley-Cox J, et al. (2010) Effects of severe mental illness on survival of people with diabetes. Br J Psychiatry 197(4):272–277.
[89] Smith M, Hopkins D, Peveler RC, et al. (2008) First-v. second-generation antipsychotics and risk for diabetes in schizophrenia: systematic review and meta-analysis. Br J Psychiatry 192(6):406–411.
[90] https://bjgp.org/content/68/669/166#xref-ref-4-1

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.

These indicators for cancer aim to increase the personalisation of cancer care and the timing of the cancer care review.

CAN001

CAN001 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.

CAN001 Reporting and verification

See indicator wording for requirement criteria.

CAN005 (based on NM204)

CAN005 Rationale

Most practices will see patients with a new cancer diagnosis following assessment and management in a secondary or tertiary care setting. This indicator aims to encourage GP practices to proactively provide patients with the opportunity for a discussion to make them aware of the support available from their GP and wider practice team. The intention is to facilitate early and supportive conversations and ensure patients are aware of what help is available.

This indicator supports recommendations 1.1.1, 1.3.4 and 1.3.5 from NICE guideline CG138 Patient experience in adult NHS services[91].

CAN005 Reporting and verification

See indicator wording for requirement criteria.

This indicator will only apply to patients who have received their diagnosis on or after 1 April 2021.

For the purposes of this indicator, the twelve-month timeframe starts from the date of diagnosis irrespective of whether or not the diagnosis was made in primary care.

CAN004 (NICE menu 2020 ID: NM205)

CAN004 Rationale

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[91] NICE CG138 (2012, updated 2021) Patient experience in adult NHS services. https://www.nice.org.uk/guidance/cg138

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, therefore primary care has an important role in supporting people to live well with and beyond cancer. This review represents an opportunity to address patients 'needs for individual assessment, care planning and on-going support and information requirements.

The Cancer Care Review should be a holistic conversation that covers clinical, practical, emotional, psychological and financial (where appropriate) aspects of the person's cancer care. The review should also consider the co-ordination of care between sectors. Practices should use Macmillan's national, integrated electronic CCR template within your Primary Care IT system to support a well-structured review. Further information on how to access Macmillan's CCR templates on all major GP IT systems can be found on the Macmillan website[92].

This template can be used as an aide memoire when carrying out a CCR. It also includes supporting information which can be shared with the patient as well as providing a helpful coded record of topics discussed.

Macmillan also provides Top Tips on Cancer Care Reviews[93] which encourages a fuller 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. Top Tips on Late Effects, Fatigue, Anxiety, Nutrition and other common problems are also available[94]. Further information on care following a cancer diagnosis and the potential role for primary care can be found on the Macmillan website[95].

CAN004 Reporting and verification

See indicator wording for requirement criteria.

For the purposes of this indicator, the twelve-month timeframe starts from the date of diagnosis irrespective of whether or not the diagnosis was made in primary care.

This indicator will not include patients whose latest unresolved cancer diagnosis was earlier than 1 January 2021 as these patients should have already been reviewed.

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

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92 https://www.macmillan.org.uk/healthcare-professionals/innovation-in-cancer-care/personalised-care#reviews
93 https://cdn.macmillan.org.uk/dfsmedia/1a6f23537f7f4519bb0cf14c45b2a629/1808-source/primary-care-top-tips-effective-cancer-care-reviews?_ga=2.92648989.1434683822.1611837616-486138938.1610014495
94 https://www.macmillan.org.uk/healthcare-professionals/news-and-resources/guides#search-result-stories-and-media_q=top%20tips&search-result-news-and-resources_e=0
95 https://www.macmillan.org.uk/about-us/health-professionals/resources/resources-for-gps.html

Chronic kidney disease (CKD)

Indicator	Points	Thresholds
Records		
CKD005. The contractor establishes and maintains a register of patients aged 18 or over with CKD with classification of categories G3a to G5 (previously stage 3 to 5)	6	N/A

CKD – rationale for inclusion of indicator set

NICE guidance[96] recommends classifying CKD using a combination of glomerular filtration rate (GFR) and albumin creatinine ratio (ACR), see description in table 1.

The Health Survey for England (2016)[97] found that 13% of adults (16 years and over) had any CKD (stages 1 to 5). The prevalence of stages 3 to 5 was 5% for all adults, rising to 34% in people aged 75 and over. At the end of 2018 there were 826 children and young people and 66,612 adults receiving renal replacement therapy in the UK according to the UK Renal Registry annual report[98].

This indicator applies to patients with category G3a, G3b, G4 and G5 CKD (GFR<60 ml/min/1.73 m² on at least 2 occasions separated by a period of at least 90 days).

Late presentation of patients with kidney failure increases morbidity, mortality and healthcare associated with costs. The total cost of CKD in England in 2009/10 was estimated as being circa £1.4 billion[99].

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

Table 1. Classification of CKD using GFR and ACR categories

	ACR category A1: normal to mildly increased (less than 3 mg/mmol)	**ACR category A2: moderately increased (3 to 30 mg/mmol)**	**ACR category A3: severely increased (over 30 mg/mmol)**
GFR category G1: normal and high (90 ml/min/1.73 m² or over)	Low risk No CKD if there are no other	Moderate risk	High risk

[96] NICE NG203 (2021) Chronic kidney disease. https://www.nice.org.uk/guidance/ng203
[97] https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/health-survey-for-england-2016
[98] https://ukkidney.org/audit-research/annual-report/22nd-annual-report-data-31122018

	markers of kidney damage		
GFR category G2: mild reduction related to normal range for a young adult (60 to 89 ml/min/1.73 m^2)	Low risk No CKD if there are no other markers of kidney damage	Moderate risk	High risk
GFR category G3a: mild to moderate reduction (45 to 59 ml/min/1.73 m^2)	Moderate risk	High risk	Very high risk
GFR category G3b: moderate to severe reduction (30 to 44 ml/min/1.73 m^2)	High risk	Very high risk	Very high risk
GFR category G4: severe reduction (15 to 29 ml/min/1.73 m^2)	Very high risk	Very high risk	Very high risk

CKD005 (NICE 2014 menu ID: NM83)

CKD005 Rationale

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

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

CKD005 Reporting and verification

See indicator wording for requirement criteria.

Epilepsy (EP)

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

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'.

EP001

EP001 Rationale

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

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

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

EP001 Reporting and verification

See indicator wording for requirement criteria.

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

Learning disabilities (LD)

Indicator	Points	Thresholds
Records		
LD004. The contractor establishes and maintains a register of patients with learning disabilities	4	N/A

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.

The health inequalities gap for people with a learning disability has increased, particularly during Covid-19. For some with a learning disability, primary care may be their only contact with health care services and so the only opportunity to support and maintain their health and wellbeing.

LD004 (NICE 2015 menu ID: NM73)

LD004 Rationale

This register indicator includes people of any age with a learning disability. This is because without a complete register of people with learning disabilities, practices may not be aware of the reasonable adjustments that may be needed for a child or young person with learning disabilities and their family, and of the help and support that may be useful to them. In order to ensure accurate recording, primary care will need to liaise with the wider health and social care network to identify and include onto the register a child or young person, with the aim to improve health outcomes through identification and prevention, utilising the guidance available where a diagnosis is not provided.

Evidence suggests there are an increasing number of children with learning disabilities now surviving childhood, some of whom will have profound and multiple disabilities as they grow up[100]. It also suggests that health services are often unprepared for these children and young people and the complexity of their problems[101].

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

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

- Lower intellectual ability (usually defined as an Intelligence Quotient [IQ] of less than 70) or a significantly reduced ability to understand new or complex information;
- Significant impairment of social or adaptive functioning; and
- Onset in childhood.

An IQ below 70 should not be used on its own to determine whether someone has a learning disability. The definition encompasses people with a broad range of disabilities. It includes adults with autism who also have learning disabilities, but not people with a higher level autistic spectrum disorder who may be of average or above average intelligence. The definition does not include all those people who have a “learning difficulty”, e.g. specific difficulties with learning, such as dyslexia.

NHS England has published guidance[102] aimed at improving the identification of people with a learning disability. Practices should review this guidance and update

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[100] Emerson, E. Estimating Future Numbers of Adults with Profound learning disabilities in England. 2009. http://www.emeraldinsight.com/doi/abs/10.1108/13595474200900040?journalCode=tldr
[101] Betz, C. Transition of Adolescents with Special Health Care Needs: review and analysis of the literature. 2004. Issues in Comprehensive Paediatric Nursing 27:179–241
[102] NHS England. 2019. Improving identification of people with a learning disability: guidance for general practice. https://www.england.nhs.uk/wp-content/uploads/2019/10/improving-identification-of-people-with-a-learning-disability-guidance-for-general-practice.pdf

their registers at least annually to ensure that they are accurate. Practices should refer to the table in appendix four 'learning disability identification check-list 'of this guidance, to assist them in identifying a person with a learning disability.

It is a statutory requirement under the Equality Act 2010 that public sector agencies make 'reasonable adjustments 'to their practice that will make them as accessible and effective as they would be for people without disabilities. Reasonable adjustments include removing physical barriers to accessing health services, but importantly also include making whatever alterations are necessary to policies, procedures, staff training and service delivery to ensure that they work equally well for people with learning disabilities[103].

LD004 Reporting and verification

See indicator wording for requirement criteria.

There was a significant revision of the clinical codes used to create this register in 2019. Full details are available in the Business Rules and coding guidance published in 2019. Where practices are cautious to add a code where there is no confirmed diagnosis, they are encouraged to use the code 'on the LD register'.

Osteoporosis: secondary prevention of fragility fractures (OST)

Indicator	Points	Thresholds
Records		
OST004. The contractor establishes and maintains a register of patients: 1. Aged 50 or over and who have not attained the age of 75 with a record of a fragility fracture on or after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and *2.* Aged 75 or over with a record of a fragility fracture on or after 1 April 2014 and a diagnosis of osteoporosis	3	N/A

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.

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

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

OST004 (NICE 2011 menu ID: NM29)

OST004 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[104], [105].

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

NICE guidance on osteoporosis fragility fractures recommends that a diagnosis of osteoporosis may be assumed in women aged 75 or over with a fragility fracture if the responsible clinician considers a DXA scan to be clinically inappropriate or unfeasible[106]. The SIGN guideline on the management of osteoporosis[107] 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

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[104] WHO. Guidelines for preclinical evaluation and clinical trials in osteoporosis. 1998.
[105] NICE CG146 (2012, updated 2017) Osteoporosis: assessing the risk of fragility fracture. http://www.nice.org.uk/guidance/CG146
[106] NICE TA161 (2008, updated 2018). Raloxifene and teriparatide for the secondary prevention of osteoporotic fragility fractures in postmenopausal women. http://www.nice.org.uk/guidance/TA161
[107] SIGN guideline 142. Management of osteoporosis and the prevention of fragility fractures. 2015. http://sign.ac.uk/pdf/SIGN142.pdf

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

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

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

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

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.

OST004 Reporting and verification

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

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

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

In patients aged 75 or over:

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

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

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

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

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

Rheumatoid arthritis (RA)

Indicator	Points	Thresholds
Records		
RA001. The contractor establishes and maintains a register of patients aged 16 or over with rheumatoid arthritis	1	N/A
Ongoing management		
RA002. The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 12 months	5	40–90%

RA – rationale for inclusion of indicator set

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

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

RA001 (NICE 2012 menu ID: NM55)

RA001 Rationale

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

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

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

- Patients who are being treated and whose disease is in remission
- Patients who are not receiving treatment for RA but have evidence of past disease, i.e. joint deformities. This type of RA is sometimes known as ‘burnt out’ RA. These patients are on the register as they remain at risk of the systemic effects of RA

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

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

Identifying recent-onset RA can be challenging in primary care because of the variety of ways in which synovitis can present itself and the small number of patients who have RA compared with the number of patients with musculoskeletal symptoms. NICE guideline NG100[108] 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.

RA001 Reporting and verification

See indicator wording for requirement criteria.

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

RA002 (NICE 2012 menu ID: NM58)

RA002 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

[108] NICE NG100 (2018, updated 2020) Rheumatoid arthritis in adults. https://www.nice.org.uk/guidance/ng100

upon a patient's quality of life. NICE guidance supports annual review. It is recommended that contractors review the following aspects of care with a patient:

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

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

RA002 Reporting and verification

See indicator wording for requirement criteria.

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

Palliative care (PC)

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

PC – rationale for inclusion of indicator set

Palliative or end of life care is the active total care of patients with life-limiting disease and their families by a multi-professional team. The first National End of Life Care (EoLC) Strategy[109] was published in July 2008 followed by:

- The National Palliative and EoLC Partnership. Ambitions for palliative and EoLC: A national framework for local action 2015-2020. http://endoflifecareambitions.org.uk/wp-content/uploads/2015/09/Ambitions-for-Palliative-and-End-of-Life-Care.pdf
- DH. Our commitment to you for EoLC: The Government response to the review of choice in EoLC. 2016. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/536326/choice-response.pdf

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

Supporting patients to make personalised end of life care plans is a key commitment in the NHS Long Term Plan.[110] There is also a commitment to improve access to palliative and end of life care for children. Timely identification of people in need of this support will be key to making these quality improvements.

PC001

PC001 Rationale

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

Identifying patients in need of palliative care, **assessing** their needs and preferences and proactively **planning** their care, are the key steps in the provision of high quality care at the end of life in general practice. This indicator is focused on identifying these patients – a critical first step in addressing the key elements of good medical practice identified by the General Medical Council.[111]

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

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

[110] NHS England. The NHS Long Term Plan. 2019. https://www.longtermplan.nhs.uk
[111] General Medical Council. 2010. Treatment and care towards the end of life: good practice in decision making. https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/treatment-and-care-towards-the-end-of-life

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

PC001 Reporting and verification

See indicator wording for requirement criteria.

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.

Non diabetic hyperglycaemia (NDH)

Indicator	Points	Thresholds
Records		
NDH001. The percentage of patients with non-diabetic hyperglycaemia who have had an HbA1c or fasting blood glucose performed in the preceding 12 months	18	50–90%

NDH – rationale for inclusion of indicator set

NDH is defined as an HbA1c of 42-47mmol/mol or a fasting plasma glucose (FPG) of 5.5-6.9mmol/l. There were 2.3million people with NDH in England in March 2021.

The NHS has invested heavily in behavioural interventions for those with NDH in order to prevent and delay the onset of Type 2 diabetes. The Healthier You: NHS Diabetes Prevention Programme (NHS DPP) is the largest undertaking of its kind in the world and over 230,000 people have already benefited since its introduction in 2016. It has proven effective at causing weight loss and reducing HbA1c.[112]

The programme is available across the whole of England, and GPs can refer patients aged 18 who have been diagnosed as having NDH in the 12 months prior to referral. Individuals with a previous history of Gestational Diabetes Mellitus (GDM) and ‘normoglycaemia ’within the 12 months prior to date of referral are also eligible. Individuals must not be pregnant, have a previous diagnosis of Type 2 Diabetes, or be recorded as living with moderate/severe frailty.

NDH001 (NICE 2017 menu ID: NM150)

NDH001 Rationale

[112] Diabetologia 2019; 62 (Suppl.1): S89

NICE Guidance (PH38[113]) recommends that everyone with NDH is offered an annual blood test to check for progression to Type 2 diabetes. Despite this there is wide variation in the monitoring of people with NDH.

The aim of this indicator is to promote early identification of when people cross the threshold into the Type 2 diabetes category, as it is associated with reduced CVD event rate and lower mortality in the individuals identified. Criteria for diagnosing diabetes are discussed in the diabetes section of this guidance.

NDH001 Reporting and verification

See indicator wording for requirement criteria.

The register for the purpose of calculating the APDF is defined as all patients aged 18 or over with a record of non-diabetic hyperglycaemia or pre-diabetes, which has not been superseded by a diagnosis of diabetes recorded prior to the beginning of the financial year.

[113] NICE PH38 (2012, updated 2017) Type 2 diabetes: prevention in people at high risk http://www.nice.org.uk/guidance/ph38

Section 4: Public Health domain

Blood pressure (BP)

Indicator	Points	Thresholds
BP002. The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years	15	50–90%

BP002 (based on NM61)

BP002 Rationale

Detecting elevated blood pressure and, where indicated, treating it, is known to be an effective health intervention. Raised blood pressure is common if it is measured on a single occasion but with repeated measurement blood pressure tends to drop. NICE guideline recommendations for the diagnosis and treatment of hypertension[114] are to be followed by practitioners when deciding on whether to treat raised blood pressure.

The age limit of aged 45 or over, has been chosen as the vast majority of patients develop hypertension after this age. The age range 45 or over, coupled with a five-year reference period is in line with the NHS Health Checks Scheme, which starts at 40 years old. It is also to align the indicator more closely with the vascular checks programme and the cost-effectiveness modelling undertaken to support that programme.

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

BP002 Reporting and verification

See indicator wording for requirement criteria.

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

Obesity (OB)

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

[114] NICE CG136 (2019) Hypertension in adults. http://www.nice.org.uk/guidance/cg136

OB – rationale for inclusion of indicator set

The Global Burden of Disease study identifies obesity as one of the top five risk factors contributing to premature death in England along with smoking, poor diet, high blood pressure and drug and alcohol use[115]. Nearly two-thirds of adults in England are living with overweight or obesity, some of the worst figures in Europe[116]. As noted in the NHS Long Term Plan obesity is linked with type 2 diabetes, high blood pressure, high cholesterol, increased rates of respiratory, musculoskeletal and liver disease and certain types of cancer.

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

Further information

- NICE has produced multiple guidelines on clinical and public health approaches to tacking obesity, they can be accessed via the NICE website: https://www.nice.org.uk/guidance/lifestyle-and-wellbeing/diet--nutrition-and-obesity

OB002

OB002 Rationale

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

NICE guideline CG189[117] recommends using BMI as a practical estimate of adiposity in adults. Identifying people with a BMI ≥25 includes a preventative aspect of care in managing obesity and supports interventions for people at risk of obesity i.e. those who are overweight but not yet obese.

OB002 Reporting and verification

See indicator wording for requirement criteria.

Smoking (SMOK)

Indicator	Points	Thresholds
Records		

[115] Steel et al. Changes in health in the countries of the UK and 150 English Local Authority areas 1990-2016: a systematic analysis for the Global Burden of disease Study 2016. The Lancet 2018;392(10158):1647-1661. https://doi.org/10.1016/S0140-6736(18)32207-4
[116] OECD. Obesity update 2017. Available from http://www.oecd.org/health/obesity-update.htm
[117] NICE CG189 (2014) Obesity. https://www.nice.org.uk/guidance/cg189

SMOK002. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months	25	50–90%
Ongoing management		
SMOK004. The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 24 months	12	40–90%
SMOK005. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 months	25	56–96%

SMOK – rationale for inclusion of indicator set

Smoking has been identified as the top modifiable risk factor for neurological diseases and premature death in England[118]. In England, 10% of pregnant women were known to be smokers at the time of delivery[119]. Smoking is linked to a wide range of disease and conditions including cancers, respiratory disease, cardiovascular disease, stomach and duodenal ulcers, erectile dysfunction and infertility, osteoporosis, cataracts, age related macular degeneration and periodontitis[120]. Smoking during pregnancy can cause serious pregnancy related health problems, these include: complications during labour and an increased risk of miscarriage, premature birth, still birth, low birth-weight and sudden unexpected death in infancy. Smoking during pregnancy also increases the risk of infant mortality by an estimated 40 per cent[121].

The aim of this domain is to increase the proportion of successful smoking quit attempts by providing the best available treatment. There is good evidence to

[118] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)01169-7/fulltext
[119] NHS Digital. Statistics on Women's Smoking Status at Time of Delivery: England Quarter 2, 2020-21: https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-women-s-smoking-status-at-time-of-delivery-england/statistics-on-womens-smoking-status-at-time-of-delivery-englandquarter-2-2020-21
[120] US DH and Human Services 2004
[121] DH. Review of the health inequalities infant mortality PSA target. 2007. http://www.perinatal.nhs.uk/smoking/Health%20Inequalities%20report%202007.pdf

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.

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

The NICE guidance on tobacco[122] identifies the evidence-based interventions for adults who smoke:

- Behavioural support (individual and group)
- Very brief advice
- Bupropion[123]
- Nicotine replacement therapy (NRT) – short and long acting
- Varenicline[124]
- Nicotine-containing e-cigarettes.

For people who smoke and who are using, or are interested in using, a nicotine-containing e-cigarette on general sale to quit smoking, NICE recommend you explain that:

- Although these products are not licensed medicines, they are regulated by the Tobacco and Related Products Regulations 2016
- There is not enough evidence to know whether there are long-term harms from e-cigarette use
- Use of e cigarettes is likely to be substantially less harmful than smoking
- Any smoking is harmful, so people using e cigarettes should stop smoking tobacco completely.

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

SMOK002 (NICE menu 2011 ID: NM38)

SMOK002 Rationale

See rationale above.

SMOK002 Reporting and verification

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[122] NICE NG209 (2021) Tobacco: preventing uptake, promoting quitting and treating dependence. https://www.nice.org.uk/guidance/ng92
[123] See information on bupropion hydrochloride in the British national formulary.
[124] See information on varenicline in the British national formulary.

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

Smokers

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

Non-smokers

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

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

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

Ex-smokers

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

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

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

SMOK004 (based on NM40)

SMOK004 Rationale

See rationale above.

SMOK004 Reporting and verification

See indicator wording for requirement criteria.

There is no APDF calculation for SMOK004.

SMOK005 (NICE 2011 menu ID: NM39)

SMOK005 Rationale

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

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

SMOK005 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.

Vaccination and Immunisations (VI)

Indicator	Points	Thresholds	Points at lower threshold
VI001. The percentage of babies who reached 8 months old in the preceding 12 months, who have received at least 3 doses of a diphtheria, tetanus and pertussis containing vaccine before the age of 8 months	18	90-95%	3
VI002. The percentage of children who reached 18 months old in the preceding 12 months, who have received at least 1 dose of MMR between the ages of 12 and 18 months	18	90-95%	7
VI003. The percentage of children who reached 5 years old in the preceding 12 months, who have received a reinforcing dose of DTaP/IPV and at least 2 doses of MMR between the ages of 1 and 5 years	18	87-95%	7
VI004. The percentage of patients who reached 80 years old in the preceding 12 months, who have received a shingles vaccine between the ages of 70 and 79 years	10	50-60%	0

VI – rationale for inclusion of indicator set

Vaccination currently prevents 2-3 million deaths worldwide every year[125]. Recently, the World Health Organization (WHO) listed vaccine hesitancy as one of their top 10 biggest threats to global health. Health workers, especially those in communities,

[125] https://www.who.int/en/news-room/fact-sheets/detail/immunization-coverage

remain the most trusted advisors and influencers of vaccination decisions, and play a key role in providing patients with trusted, credible information on vaccines[126].

VI001 (NICE 2020 menu ID: NM197)

VI001 Rationale

Diphtheria, tetanus and pertussis (whooping cough) are acute infectious diseases that can have severe complications. The routine immunisation schedule states that the hexavalent (6-in-1) vaccine is due at 8, 12 and 16 weeks old for immunisation to diphtheria, tetanus and pertussis (DTaP) as well as poliomyelitis (IPV), haemophilus influenzae type B (Hib) and hepatitis B (Public Health England 2020).

The indicator supports early vaccination according to the routine immunisation schedule. Measurement by 8 months old allows for vaccination deferral due to febrile illness but aims to achieve immunisation against the named acute infectious diseases as early as possible.

VI001 Reporting and verification

See indicator wording for requirement criteria.

The only personalised care adjustment applicable is where the intervention described in the indicator is contraindicated for the patient.

VI002 (NICE 2020 menu ID: NM198)

VI002 Rationale

MMR is the combined vaccine that protects against measles, mumps and rubella. These are highly infectious conditions that can have serious complications such as meningitis and encephalitis. The first MMR vaccine (MMR1) is due as part of the routine vaccination schedule for England within a month of the child's first birthday (Public Health England 2020).

The indicator supports early vaccination with the first dose of the MMR vaccine according to the routine immunisation schedule. Measurement by 18 months old allows for vaccination deferral due to febrile illness but aims to achieve vaccination as early as possible.

VI002 Reporting and verification

See indicator wording for requirement criteria.

The only personalised care adjustment applicable is where the intervention described in the indicator is contraindicated for the patient.

VI003 (NICE 2020 menu ID: NM199)

VI003 Rationale

[126] https://www.who.int/news-room/spotlight/ten-threats-to-global-health-in-2019

The indicator supports immunisation according to the routine immunisation schedule. Measurement by 5 years old aims to achieve full immunisation against these infectious diseases before children start school.

VI003 Reporting and verification

See indicator wording for requirement criteria.

The only personalised care adjustment applicable is where the intervention described in the indicator is contraindicated for the patient.

VI004 (based on NM201)

VI004 Rationale

Shingles is caused by the reactivation of a latent varicella zoster virus infection. Incidence and severity of disease are associated with increasing age. The routine immunisation schedule states that the shingles vaccine is due at 70 years old (Public Health England 2020). Patients remain eligible for the vaccination until their 80th birthday.

The indicator supports vaccination against shingles for patients 70 years old and over. The effectiveness of the shingles vaccine decreases with increasing age so earlier vaccination is encouraged to ensure optimal protection against shingles.

VI004 Reporting and verification

See indicator wording for requirement criteria. Patients should have received a complete course to be included in the numerator for this indicator. Practices may use a personalised care adjustment if the vaccine is contraindicated or if the patient has declined vaccination.

Public health domain – additional services

For contractors providing additional services the following indicators apply.

Cervical screening (CS)

Indicator	Points	Thresholds
CS005. The proportion of women eligible for screening aged 25-49 years at end of period reported whose notes record that an adequate cervical screening test has been performed in the previous 3 years and 6 months	7	45-80%
CS006. The proportion of women eligible for screening and aged 50-64 years at end of period reported whose notes record that an adequate cervical screening test has been performed in the previous 5 years and 6 months	4	45-80%

CS indicator 005 (NICE 2017 menu ID: NM154)

CS indicator 006 (NICE 2017 menu ID: NM155)

CS005 and CS006 Rationale

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

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

CS005 and CS006 Reporting and verification

See indicator wording for requirement criteria.

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

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

Section 5: Quality Improvement domain

Prescription Drug Dependency

Indicator	Points	Thresholds
QIPDD009. The contractor can demonstrate continuous quality improvement activity focused upon prescription drug dependency as specified in the QOF guidance	27	N/A
QIPDD010. The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity focused on prescription drug dependency as specified in the QOF guidance. This would usually include participating in a minimum of two peer review meetings	10	N/A

Optimising Access To General Practice

Indicator	Points	Thresholds
QIOA011. The contractor can demonstrate continuous quality improvement activity focused on optimising access to General Practice as specified in the QOF guidance	27	N/A
QIOA012. The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity focused on optimising access to General Practice as specified in the QOF guidance. This would usually include participating in a minimum of two network peer review meetings	10	N/A

Rationale for inclusion of a Quality Improvement domain

The aim of this domain is to provide support for contractors and their staff to recognise areas of care which require improvement, and take steps to address this through the development and implementation of a quality improvement plan and sharing of learning across their network. Being skilled in quality improvement has been recognised as a key role for healthcare professionals in the Shared View of Quality[127].

Practices are also encouraged to consider how their activity may support research and innovation within primary care. Covid-19 has highlighted that when front line nurses, doctors and other health professionals work with research teams to embed research in care and treatment pathways, we can give more people an opportunity to

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

get involved in and benefit from research. The evidence generated by research improves patient care and quality of life. Covid-19 has also demonstrated the value of innovation in tackling and responding to key health challenges. NHSE is committed to supporting more practices, staff and patients to get involved in research and proven innovation.

NHS England and GPC England have worked with the Royal College of General Practitioners, NICE and the Health Foundation to develop the topic specific guidance on prescription drug dependency. We have worked with the London access team when developing the guidance on optimising access.

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

The two topic areas for 2022/23 are prescription drug dependency and, optimising access to General Practice.

Through practice engagement with these and future modules, we expect to see measurable improvement in the quality of care and patient experience at a national level against the areas of focus described in the individual modules – though we recognise that in some instances these improvements may only be realised with a lag, i.e. after the end of 2022/23. Furthermore, while we expect to see measurable improvements at a *national* level, we also recognise that not all quality improvement activity at a *practice* level will be successful in terms of its impact upon patient care. Where an individual practice undertakes a QI project but does not observe measurable improvements, this should not necessarily be taken as a sign of failure, as the learning from this project may be used to inform future improvement activities.

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

All the supporting information and resources referred to in this guidance will be made available on NHS England's website by the end of March 2022. Further information as to how to undertake quality improvement activities is available from a number of sources including:

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

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

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

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

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

Institute for Health Improvement (http://www.ihi.org/) – a US site with a range of resources to support QI activity.

NHSE/I resources to support working with people and communities Primary Care Networks Development Support - Integrated Care (future.nhs.uk)

For further information on how practices can get more involved in the primary care research community and receive support in adopting proven innovation is available from a number of sources:

Academic Health Science Networks (https://www.ahsnnetwork.com/) – There are 15 Academic Health Science Networks (AHSNs) across England, established by NHS England in 2013 to spread innovation at pace and scale. Their site includes tools, resources and case studies for healthcare innovation as well as contact details for each AHSN to request further information or support.

NIHR – The National Institute for Health Research (NIHR) is the research arm of the NHS. They provide funding for research studies as well as academic training, facilities, career development and research capability development. See https://www.spcr.nihr.ac.uk/about-us or contact signposting@nihr.ac.uk for more information on NIHR's support offer.

NIHR Learn – "The Research and Quality Improvement Learning Community for Primary Care" through NIHR Learn including account registration can be accessed here: https://learn.nihr.ac.uk

Prescription Drug Dependency

Rationale

Prescription medicines associated with dependence or withdrawal symptoms (dependence forming medications or DFMs) are widely prescribed and include opioid pain medicines, gabapentinoids, benzodiazepines and z-drugs. Public Health England's analysis (PHE 2019[128]) showed that, in 2017 to 2018, large numbers of adults in England (26% of the adult population) were dispensed one or more prescriptions for:

- Opioid pain medicines 5.6 million (13%)
- Gabapentinoids 1.5 million (3%)
- Benzodiazepines 1.4 million (3%)
- Z-drugs 1.0 million (2%)

Opioids are very valuable drugs for acute and palliative/end of life care but have a limited role in the management of chronic pain; for many patients they are not effective. Most prescribing is of short duration only; however, 3% of patients (CQC, 2020[2]) with chronic pain receive continuing prescriptions for opioids for 3 years or more. Prolonged prescribing of these drugs may not be effective and is associated with dependence. Withdrawal symptoms from medicines in these classes may last many months and can affect patients 'physical, mental and social wellbeing (NICE 2019[129], BMA, 2015[130]).

Gabapentinoid prescribing has shown a 10 fold increase between 2000 and 2015 from 0.2% of patients in 2000 to 2.1% in 2015 (Cartagena et al. 2017), most of which has been off label and of unknown effectiveness; dependence on these drugs is increasingly recognised as a problem.

Prescribing of DFMs varies between CCGs, between practices, and between GPs in a practice. Opioid and gabapentinoid prescribing is strongly associated with deprivation. The rate and duration of prescribing, and prescribing of more than one class of DFM, increases with levels of deprivation in the patient's neighbourhood of residence (PHE, 2019[131]). Consideration should be given to targeting any QI project at patient groups, cohorts or neighbourhoods that are known to experience higher rates of prescription drug dependency.

Focused changes in prescribing practice at initial consultation and review of treatment can help overcome issues of prescribing outside guidance, over-prescribing and the risk of dependence and symptoms of withdrawal. Greater consideration of these issues when considering a patient's first prescription and

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[128] https://www.gov.uk/government/publications/prescribed-medicines-review-report
[129] https://cks.nice.org.uk/benzodiazepine-and-z-drug-withdrawal
[130] http://bmaopac.hosted.exlibrisgroup.com/exlibris/aleph/a23_1/apache_media/H6IB5G1BL8SX1KJ7VY4MCRCXVG6EV7.pdf
[131] https://www.gov.uk/government/publications/prescribed-medicines-review-report

when reviewing medications can help to ensure that patients receive appropriate medication (RCGP 2017[132]).

Where prescribing of DFMs is initiated, this should be of specified duration, within guidelines and subject to regular review. CQC recommend that prescribers should regularly review patients 'clinical needs before prescribing controlled drugs and consider the quantity prescribed, particularly when issuing repeat prescriptions. They also encourage healthcare professionals to fully explain patients 'medicines at the point of prescribing and supply. This should include giving guidance and warnings of the potential for dependence and actions to take, appropriate to the patient's needs (CQC, 2020).

General practice can further support appropriate prescribing by increasing the involvement of the patient through shared decision making and increasing patient awareness of non-pharmacological support and interventions, and how to access these, either as an alternative to medication or with the aim of reducing the duration of treatment (NICE 2015[133]).

Overview of the QI module

The overarching aim of this QI module is to lead to improvements in relation to the following aspects of prescribing safety:

- Use of non-pharmacological alternatives rather than initiation of DFMs in line with best evidence and guidance;
- Structured medication reviews of patients taking 120mg oral morphine equivalent (OME) or more for chronic pain;
- Structured medication reviews where there is polypharmacy or inappropriate use of dependence forming medications.

The outcomes listed below will be used at a *national level* to assess the impact of the module; this assessment will extend beyond 2022/23, in recognition that some QI activities will take some time to translate into measurable improvements. Practices should consider how their work can contribute to improvements when choosing practice-based aims for their projects.

1. Reduced initiation of the prescribing of medicines that may cause dependence.
2. Reduced duration of courses of medicines that may cause dependence.
3. Increased take-up of non-pharmacological support and interventions.
4. Improved patient understanding of the potential benefits and harm of treatment options to enable informed participation in shared decision making.
5. Non initiation of other groups of drugs at risk of dependence and misuse – e.g. ketamine / quetiapine.

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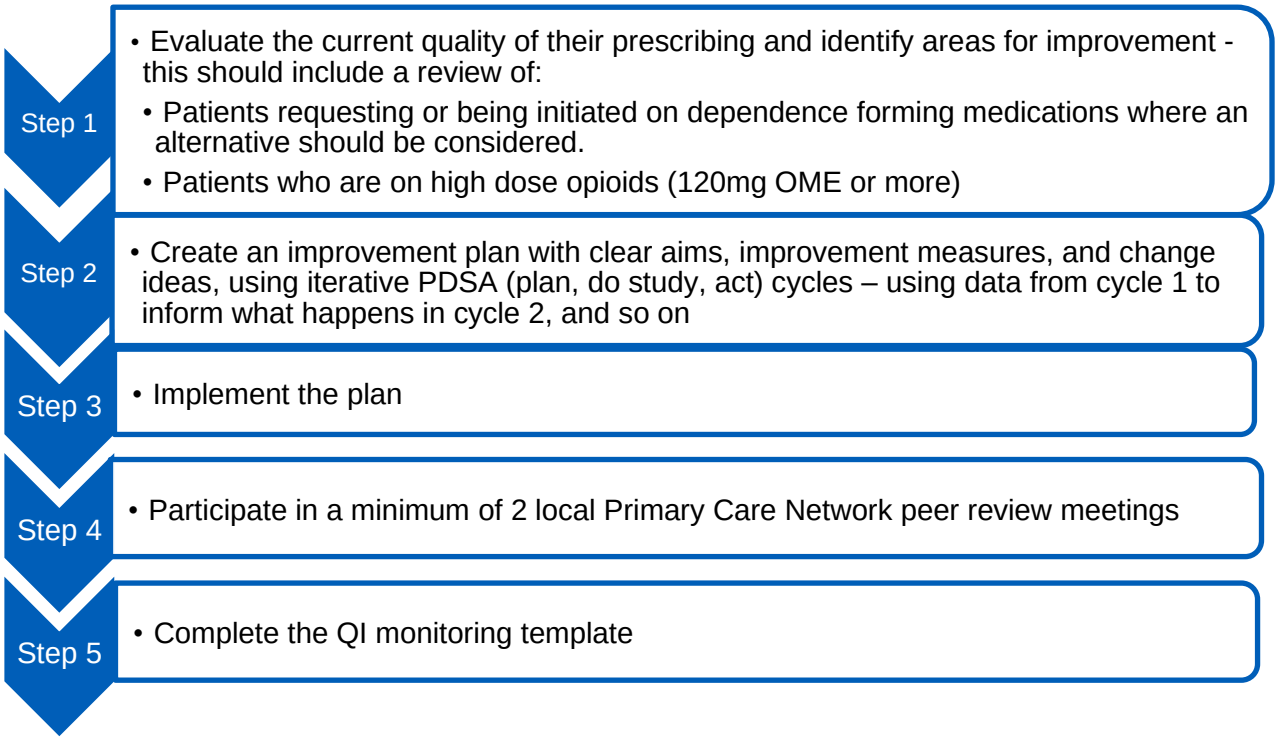
[132] https://www.rcgp.org.uk/clinical-and-research/resources/a-to-z-clinical-resources/dependence-forming-medications.aspx
[133] https://www.nice.org.uk/guidance/ng5

This guidance relates to QI activity and does **not** constitute prescribing guidance, nor does it replace the need for individual clinical judgement. The remit of this guidance does not cover use of these medications for management of acute pain, pain associated with cancer or during end of life care and does not apply to the use of these medications for non-pain related clinical indications such as epilepsy.

Practices will need to undertake the following steps:



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

Practices should focus their QI activity on clinical priorities identified within their population with an initial focus on reducing initiation of these medications and the safety of high dose opioid prescribing and polypharmacy before moving onto tackle general de-prescribing. Practices can build on previous improvement work they have undertaken.

Detailed Contractor Guidance

1. Identifying areas for improvement

Where possible, practices should involve practice-based clinical pharmacists, local community pharmacists, community support/ social prescribing link workers, chronic pain teams, drug dependency services, specialist third sector organisations, local out of hours and secondary care providers in creating and implementing QI plans. All practices should start by assessing the current quality of care they provide. This should consider all of the following:

1. Identifying baseline activity of initiation of DFMs by, for example, choosing four weeks activity and measuring the number of patients initiated on such drugs in that period. Practices will need to choose a meaningful and realistic time period which will vary by practice. Practices may need to focus on only one dependency forming drug group when looking at initiation and should also consider reviewing individual clinician variation.
2. Identifying patients on high dose opioids for chronic pain (120mg oral morphine equivalent (OME) or more).
3. Identifying patients on more than one dependency forming drug. Practices will need to choose if they wish to examine all such polypharmacy (i.e. all patients on 2, 3, 4 or more drugs that may form dependency) or concentrate on a particular area (e.g. two such drugs). This will relate to how much of an issue dependency forming drug polypharmacy is for the practice.

Practices should consider what QI tools and techniques are most suitable to support their improvement project. Examples include:

- Undertaking a reflective group meeting and/ or complete a SWOT (strengths, weaknesses, opportunities, threats) analysis of the practice's approach to diagnosing, treating and supporting people with chronic pain and / or insomnia, or people with prescribed drug dependency.
- A multidisciplinary team undertaking sample case-based discussions as a group to identify unwarranted variation in practice such as prescribing, recommendation of alternatives, use of shared decision-making, or use of evidence-based guidelines and clinical templates in practice.
- Undertaking a staff survey to test awareness, knowledge and confidence in managing difficult consultations related to DFMs.
- Clinicians undertaking an enhanced significant event analysis[134] (SEA) into any patient safety issues that arise from prescribed drug dependency to identify areas for improvement.
- Patients and staff using process mapping[135] to identify ways to access non-pharmacological or community-based alternatives.
- Creating a driver diagram to identify the factors that may need to be changed to bring about improvement.
- Exploring information resources that are made available to patients to support shared decision making.

Tools that can be used to help evaluate whether changes are creating improvements:

[134] https://qiready.rcgp.org.uk/resources/rcgp-quick-guide-significant-event-analysis/#.XX-Z8ihKhQA
[135] https://qiready.rcgp.org.uk/resources/rcgp-quick-guide-process-and-value-stream-mapping/#.XX-alihKhQA

- Undertaking PDSA cycles[136] (plan, do, study, act) to test changes to clinical practice in identifying people with anxiety or depression such as inclusion of screening questions by staff during appointments for new patient registrations, long term condition management or medication reviews.
- Devising run charts[137] to illustrate the changes in the chosen measures over time to make it easy to see any improvements being made.

Further resources including links to relevant clinical guidance such as management of musculoskeletal pain or chronic pain, management of insomnia, and management of prescription drug dependency can be found in the Appendices.

Guidance on basic QI concepts and tools can be found in the NHS England *An Introduction to Quality Improvement in General Practice*[138] and the RCGP QI Ready tool[139].

2. Creating an improvement plan

Once practices have identified their area/s for improvement they must decide:

- **The aim(s)** of the project – what will be achieved and by when. These aims should be SMART (specific, measurable, achievable, relevant, and time-bound).
- **The measure(s)** – what data will be collected to know if the aims have been met. Measurements to assess the effectiveness of changes made should be straightforward for teams to collect regularly.
- **The changes** – what different ways of doing things will be tested.

Practices should choose their own QI activities and set their own targets for improvement based upon their baseline audit or search results, recognising this will vary between practices according to many factors including population, previous prescribing behaviours and past improvement work. See Box 1 for examples of SMART aims.

[136] https://qiready.rcgp.org.uk/resources/rcgp-quick-guide-plan-study-act-pdsa-approach/#.XX-Z3yhKhQA
[137] https://qiready.rcgp.org.uk/resources/rcgp-quick-guide-run-charts/#.XeUTnej7RQA
[138] https://www.england.nhs.uk/publication/an-introduction-to-quality-improvement-in-general-practice/
[139] https://qiready.rcgp.org.uk/

Box 1: Examples of SMART aims*

Area for improvement 1: A baseline staff survey identified considerable variation in clinician confidence in discussing alternatives to drug prescribing for patients presenting with chronic pain alongside parallel variation in the individual clinician prescribing patterns over the past 6 months.

SMART aim: Following a dedicated training session on managing chronic pain and sharing of e-learning resources, a repeat staff survey 6 months later shows improved confidence levels for all clinicians with less variation.

SMART aim: 3 monthly prescribing searches for initiation of opioids for chronic pain show a consistent reduction in the number of initiations with reducing variation of between the clinicians with the highest and lowest prescribing rates.

Area for improvement 2: Baseline practice prescribing analysis identifies X% patients on high dose opioids (120mg OME or more daily) which was in upper quartile for England.

SMART aim: All patients on high dose opioids have a structured medication review and individualised treatment plan reviewed a minimum of every 6 months.

SMART aim: A search of patients prescribed high dose opioids (120mg OME or more daily) run every month shows a reducing trend over the year.

Area for improvement 3: Baseline practice prescribing shows X new prescriptions for dependence forming medications issued in the last month with no consultations showing evidence of non-pharmacological alternatives being discussed with the patient.

SMART aim: All patients initiated on a dependence forming medication have clearly documented consultation showing evidence of non-pharmacological alternatives being discussed.

Area for improvement 4: Baseline practice prescribing analysis demonstrates that 50% of patients prescribed a z-drug or benzodiazepine in the last 3 months had been receiving repeat prescriptions for one year or more.

SMART aim: For new initiations of z drugs or benzos issued in the last 3 months, none are for courses over 14 days and no patients have received a repeat course within the 3 months test period.

*These are suggestions only. Practices must decide their own SMART aims based on their own data and improvement ideas. Practices may consider shared aims across a primary care network.

3. Implementing the plan

Practices should implement the improvement plan to achieve the aims they have chosen. These should be challenging but realistic and recognise that it may be easier to make larger improvements when starting from a modest baseline. These should be validated by network peers as part of the initial network review meeting. Multiple small tests or rapid cycles of change are recommended. Practices should aim to find a way to ensure improvement is continuous and that quality improvement becomes routine.

Changes to systems as well as change in individual practitioner behaviours should be implemented. Structured medication reviews should be sensitive to the specific hazards relating to dependence forming drugs.

Where possible, patients should be involved in quality improvement activity. At the most basic level this would involve discussion of planned activity with the practice patient participation group but could involve surveys and or focus groups where relevant. Opportunities to gather reflective statements from staff and any feedback from patients are encouraged. These responses can help inform current and future work.

4. Primary Care network peer review meetings

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

The peer review group will usually be the Primary Care Network of which the practice is a member. Where the practice is not part of a network their peer review group should be agreed with the commissioner.

The Network Clinical Lead should choose a suitable facilitator to support sharing of learning and quality improvement. For example, this could be the Network Clinical Lead, another network clinician, a practice manager, or alternatively someone external. A record of attendance should be kept, and it is recommended that the Network Clinical Lead and Network Health Inequalities Lead attend, irrespective of who facilitates the meetings.

It is for the network to determine the timing of these meetings, but it is recommended that the first meeting takes place early in the QI activity at the stage of deciding on what quality improvement activities to undertake and the second towards the end to share outcomes and learning from these activities.

Suggested discussion points for these meetings are made in Box 2.

Box 2: Suggested peer review meeting discussion points

The **first peer review meeting** should take place early in the QI activity and should focus on:

- Sharing the outputs of baseline work to understand the issues for each practice, including the agreed targeted population groups, e.g.:
  - Non-initiation of DFMs
  - High dose opioid prescribing for chronic pain
  - DFM polypharmacy
  - Inappropriate DFM use (e.g. for longer than evidence indicates is helpful)
- Validation of practice improvement targets.

Discussion points could include:

1. What relevant evidence-based guidance / quality standards can the group use?
2. What data has each practice used to inform its review of current performance?
3. Has the right focus been chosen by each practice based on their current performance?
4. Has each practice set a clear aim with a challenging but realistic local target, and agreed an appropriate measurement to monitor impact?
5. What ideas for changes is each practice planning to try in an improvement cycle?
6. How are practices ensuring that the whole practice team (including other clinical colleagues and patients and carers) are engaged in the proposed QI activity?
7. What existing community services/assets could be engaged to support the work (other NHS, VCSE, third sector)?

The **second peer review meeting** should take place towards the end of the QI activity and focus on:

- Celebrating success and sharing of key changes made in practice.
- Encouraging a compassionate, no-blame and active learning culture.

How these changes have been embedded and will be sustained.

Discussion points could include:

1. What results have each practice seen in their QI activity testing?
2. What changes have been adopted in each practice?
3. How will these changes be sustained in the future?
4. What new skills have staff developed and how can they be used next?
5. What further QI activity is planned in each practice?
6. What further actions may need to take place (e.g. at network or CCG level) to support the changes in practices?
7. Which QI tools were/ not most helpful, and why?

5. Reporting and verification

The practice will need to complete the QI monitoring template below, in relation to this module and self-declare that they have completed the activity described in their QI plan. The practice will also self-declare that they have attended a minimum of two peer review meetings as described above, unless there are exceptional and unforeseen circumstances which impact upon a practice's ability to participate. In these circumstances, practices are expected to make efforts to ensure alternative participation in peer review.

Verification: Commissioners may require practices to provide a copy of the QI monitoring template as written evidence that the quality improvement activity has been undertaken. Commissioners may require the network clinical lead to provide written evidence of attendance at the peer review meetings. If a practice has been unable to attend a meeting due to exceptional circumstances, then they will need to demonstrate other active engagement in network peer learning and review.

Resources are available to support available from
www.england.nhs.uk/gp/investment/gp-contract/

6. Reporting Template

It is anticipated that the responses noted here should total a maximum of 2 A4 sides in Arial font size 11.

Practice name and ODS code
What area of practice did the practice identify for quality improvement?
What was the defined “Smart Aim” of your quality improvement work
What were the changes that you tested?
What changes have been adopted?
How will these changes be sustained in the future?
What measures/indicators did you use to track your improvement?
Did you observe improvements in relation to these measures/indicators? Please provide details of any improvements achieved.

What have been the benefits to patients over the course of the quality improvement project, who were either identified as having been on ≥120mg oral morphine equivalent (OME) for chronic pain or who were identified as having polypharmacy of dependence forming medications?
How many patients over the course of the quality improvement project, on 120mg morphine equivalent (OME) for chronic pain received a structured medication review?
How many patients on 120mg oral morphine equivalent (OME) for chronic pain received a structured medication review?
How did the network peer support meetings and patient participation influence the practice's QI plans and understanding of prescription drug dependence?
Optional: We would be very grateful if you would consider sharing your improvement project as an example of good practice. If you would be willing to do this, please upload it to the National Prescribing and Medicines Optimisation Community - FutureNHS Collaboration Platform

Optimising Access to General Practice

Rationale

Access to General Practice is a complex and longstanding challenge which has been further exacerbated by the pressures of the pandemic.

COVID-19 has precipitated unprecedented changes in service delivery and ways of working within general practice. Practices and patients have had to adapt very quickly to a new way of delivering care including the rapid adoption and use of digital tools and embedding triage processes and new pathways. A review of GP access during the pandemic by Healthwatch England[140] found some people were struggling to book appointments and access treatment. The main point raised was that there is no 'one size fits all 'approach – it is important to ensure access remains inclusive by offering a choice of different access routes and to personalise care delivery to meet different patient needs.

Over the last five years, General Practice workload has grown in both volume and complexity, with a growing number of patients living with multimorbidity who need ongoing care. And despite an expansion in the number of additional clinical roles within General Practices and the creation of multi-disciplinary teams, pressure on access to appointments remains a significant challenge.

Recent academic studies have also highlighted the importance of continuity of care. Greater continuity with a primary care physician has been shown to be associated with lower mortality rates,[141] fewer hospital admissions[142,143], less use of emergency departments,[144] and fewer referrals for specialist health care.[145]

In October 2021, NHSEI published plans on how it would improve access for patients and support GP practices in doing so[146]. One of the commitments made was to 'commission an additional QOF improvement module, focused on optimal models of access including triage and appointment type'. This QI module aims to complement the work already being done in practices and work being led through the National Access Improvement Programme.

It is important to recognise that, despite the many challenges, overall public satisfaction with General Practice as reported in the annual GP Patient survey remains high (83% reported a good experience of their GP practice in the 2021 GP survey, compared to 82% in 2020). However, with the increased demand for

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[140] Microsoft Word - 20210215 GP access during COVID19 report final (healthwatch.co.uk)
[141] Continuity of care in family practice. Part 2: implications of continuity - PubMed (nih.gov)
[142] Continuity of care with doctors—a matter of life and death? A systematic review of continuity of care and mortality | BMJ Open
[143] Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: cross sectional study of routinely collected, person level data | The BMJ
[144] Characteristics of general practices associated with emergency-department attendance rates: a cross-sectional study | BMJ Quality & Safety
[145] Continuity of primary care and emergency department utilization among elderly people | CMAJ
[146] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2021/10/BW999-our-plan-for-improving-access-and-supporting-general-practice-oct-21.pdf

appointments it is more important than ever that practices can better match demand to the right capacity, optimising use of the multi-disciplinary team and wider primary care services, alongside the use of care navigation and triage to ensure access to care is equitable. As the model of access to General Practice continues to evolve, we must remain proactive to ensure implementation remains inclusive for all patients.

Overview of the QI module

The overarching objective of this QI module is to contribute to improvements in access to general practice, in relation to the following aspects:

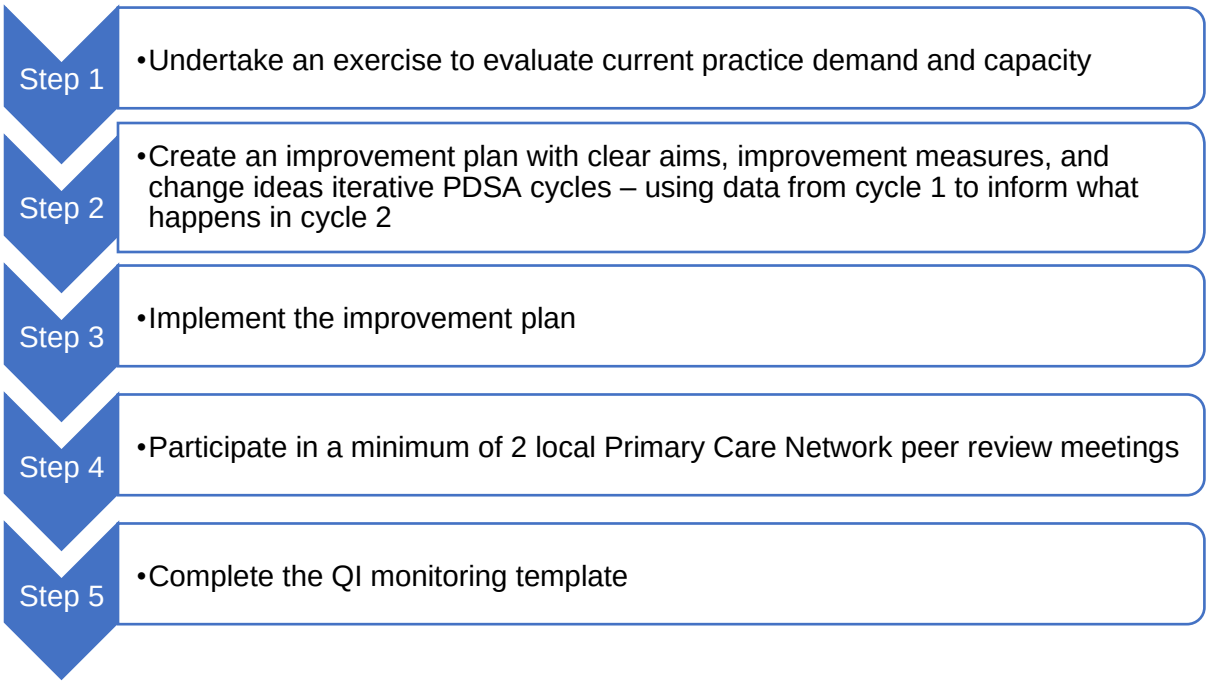
Understanding of demand and capacity within the practice (and PCN) and using a QI approach to optimise capacity. This will involve understanding the reasons for patient contacts and the types of appointments available as a practice and at PCN level.

a. Undertaking a review as a practice and PCN to better understand the skills available across your team and PCN and to better match demand and optimise use of capacity. This may include reviewing areas such as care navigation and triage pathways within the Practice/PCN; staff rotas and demand patterns; use of digital tools; use of practice nurses and ARRS staff; and use of wider primary care services e.g. the Community Pharmacist Consultation Service (CPCS) and other similar schemes.

b. Working with your practice patients and carers to understand views around access issues, including: ease of contacting the practice to obtain advice or an appointment, communications including website, local population who are at risk of inequalities with regards to access etc, and to co-produce an access improvement plan.

c. Considering access beyond the practice by reviewing links/pathways with parts of the system beyond the practice and PCN e.g. local authority or third sector groups offering local services to identify opportunities for collaborative working which may support access.

Practices will need to undertake the following steps:



The following section includes further detail on the types of things practices could do to deliver this module. These are suggestions and recommendations only and the decision about what to include in the QI plan and which QI methodologies to use should be made by practices and shared with their peers through the network meetings. Ideally the improvement plan will contain work that will support improvement in all three parts of objectives listed above; better understand the skills available across your team and PCN, understand views around access issues and, consider access beyond the practice by reviewing links/pathways with parts of the system beyond the practice and PCN.

Practices are expected to undertake quality improvement activity in both evaluating the current demand and capacity for the practice and in undertaking actions in partnership with their PCN and patients to optimise access to their practice.

Detailed Contractor Guidance

1. Identifying areas for improvement

All practices should start with an assessment of the current access that they provide to patients taking into account local health inequalities. Practices are able to make use of the London General Practice Access Guide and Manual[147] especially Chapter 2 “General Practice Activity” when evaluating their demand and capacity.

It is anticipated that practice QI activity will dovetail with both local priorities and wider optimising access activities. Practices are expected to seek the views of patients and carers where this will help with quality improvement activity. This could be done through engagement with a patient participation group and/ or a survey of patients. Chapter 3 of the London General Practice Access Guide and Manual

[147] https://www.healthylondon.org/our-work/primary-care/gp-access/

focuses on working with patients to improve access. Practices may also find it useful to undertake a reflective group meeting and complete a 'SWOT '(strengths, weaknesses, opportunities and threats) analysis. Guidance can be found in the RCGP publication: How to get started in QI.

2. Creating an improvement plan

Following the diagnostic phase above, practices should focus their QI activities on outcomes that could include the following (noting that these are suggestions and the decision about what to plan will be made by practices):

Demand and Capacity

a. Reducing unmet need, and increasing rates of appointments offered/taken up by patient groups identified locally as priority (due to risk of health inequalities)

b. Increasing overall appointment volumes in general practice and optimising the numbers of appointments with ARRS staff to best meet the needs of patients

c. Decreasing the rate of repeat appointments for same issue (at a practice or PCN level)

d. Decreasing the rate of patients experiencing long waits for an appointment (and prioritisation based on clinical need)

a. Optimising use of capacity and the mix of appointment modes to match patient presentations and demand (encompassing not just general practice but also community pharmacy, Accident & Emergency, NHS 111 and others)

e. Developing strategies to more effectively support high frequency service users (including high frequency users of general practice, secondary care, and other care pathways).

f. Improving the ability of patients to contact the practice

Patient and Staff Satisfaction

g. Improving patient satisfaction with General Practice including: the ability to contact the practice to seek care or advice; appointment timing; appointment mode; continuity of care; and the type of healthcare professional they saw.

h. Improving staff experience of working in general practice, through better management of demand and capacity.

Utilisation of wider system support

i. Increasing onward referrals/signposting to other non-clinical local services (including the Voluntary and Community Sector (VCS), and Local Authorities (LAs)

j. Increasing utilisation of the CPCS for minor illnesses

These outcomes will be used at a national level to assess the impact of the module and practices should consider how they measure improvement when choosing aims for their projects.

Once practices have identified their area/s for improvement they should be clear about:

- The **aims** of the project – what will be achieved and by when. These aims should be SMART (specific, measurable, achievable, relevant, and time-bound).
- The **measures** – what data will be collected to know if the aims have been met. Measurements to assess the effectiveness of changes made should be straightforward to collect regularly. Practice project measures could be stratified into:
    - **Process**, e.g. Number of appointments broken down by mode, clinician type, and attendance status (whether the patient attended or did not attend).
    - **Outcomes**, e.g. Patient experience of general practice, length of wait on the telephone, waiting time for an appointment
    - **Balancing**, e.g. Continuity of care.
- **The changes** – what different ways of doing things will be tested e.g. new models of contact, shift in tasks to other clinicians and/or staff

Box 3: Examples of SMART goals

Area for improvement 1: The practice had little understanding of their demand and capacity and how it varied throughout the week and year; 'reactive demand'.

SMART aim: To understand how demand varies throughout the week and year to plan capacity.
Actions:

- Identify appointment slots used to book 'reactive demand'.
- Count (or search) booked 'reactive demand 'appointment slots over previous 12 weeks, by day of the week. Observe how it varies over time.
- Plot data on a run chart
- Use this data to predict the demand each day for the next 2 weeks
- Check each day how close the predicted demand is to the actual demand
- Use data to plan capacity

SMART aim: To measure the unmet (expressed) demand e.g. a patient contacts the practice seeking care or advice and is told to contact the practice again at another time or go to another care setting e.g. 111 for triage
Actions:

- Reception/Admin teams count 'unmet need 'every day for 2 weeks.
- Use this data alongside other appointment data (i.e. scheduled work (booked appointments) and any extra appointments that get 'squeezed in 'or added onto daily scheduled work to help with predicting future demand and planning capacity that is needed to meet this demand.

Area for improvement 2: The practice did not reliably code data on appointment/consultation type/mode and was unable to describe how care encounters were taking place and to distinguish consultations from other work

such as administrative work to help with understanding of demand and capacity

SMART aim: To describe how care encounters were taking place and differentiate care encounters from other work.
Actions:

- Team reviews appointment/consultation (encounter) types currently in use
- Agrees standard way of capturing appointment/consultation modes e.g. face-to-face, telephone, video, home visit
- Re-audit after one month to check that agreed appointment/consultation modes are being used consistently across the team

Area for improvement 3: Following a discussion at a practice team meeting about re-attendance, the practice wanted a better understanding of appropriateness and variation in re-attendance rates to see if there was an opportunity to review how capacity is being used.

SMART aim: To identify the proportion of re-attendance which may be avoidable.
Actions:

- Each clinician searches for 10 patients who have re-attended within 14 days of an initial contact
- In a team meeting, undertake a focused review of the reason for re-attendance
- Identify the proportion of attendances that may be avoidable e.g. routine follow-up, normal test result or administrative issue

Area for improvement 4: The practice had received several complaints from patients who were unable to access appointments and wanted to improve the appointment process.

SMART aim: To identify troublesome points or bottlenecks in booking appointments.
Actions:

- As a practice team, map the appointment booking process to identify troublesome points such as bottlenecks and queues, for troublesome points.
- Work collaboratively to generate and test potential solutions.

NB: This process mapping exercise is even more impactful if it is done with patients/carers as well as the practice team. Seeing the process from others 'point of view often reveals the most important problems. An extra qualitative dimension can be added by using an emotional journey map to associate an indication of the emotional status of the user at each stage in the process.

Area for improvement 5: At a practice team meeting, GPs expressed a large amount of time is taken up with non-clinical work e.g. completing follow up administrative tasks.

SMART aim: To test how much GP time could be saved by administrative staff members assisting GPs during their morning telephone clinics.
Actions:

- A plan for how practices introduced buddying can be found here
- Start with one hour of buddying time and learn as much as possible

- Continue with testing and learning from each other and bring in other team members as the process is refined.

Area for improvement 6: The practice did not have a system to identify people who may find it more difficult to use online access or remote consultations.

SMART aim: To ensure groups at risk of digital exclusion are identified by adding a flag on their medical record.
Actions:

- Review Nuffield Trust publication on digital and remote primary care
- Search for patient groups most at risk from digital exclusion e.g. Black or Asian ethnicity, learning or physical disability, language needs or carers
- Flag risk of exclusion as an alert on the medical record
- Focus opportunistically on identifying individual preferences on how to access care when consulting or registering patients at increased risk of difficulty accessing primary care, and flag this on the medical record.

Area for improvement 7: The practice had received several complaints about continuity of care and wanted to improve continuity of care for specific patients.

SMART aim: To identify which patients may benefit from new ways of working to improve continuity of care.
Actions:

- Search for patients who have attended more than 5 times in a 3 month period
- In a team meeting undertake a focused review of a sample of the patients identified and count the number of different members of the clinical team who have been involved in their care during those attendances
- If low continuity is identified consider testing out ways to improve continuity such as: clearly communicating the days of the week the patient's 'usual doctor 'is working, identifying cohorts of patients who may benefit most from continuity of care and flagging their record using alerts, using micro teams – with GP, nurse, administrators and other team members e.g. pharmacist, social prescribing link workers, to provide team continuity for groups of patients
- Re-run the searches after 3 months to identify the impact of and tests of change on continuity.

Area for improvement 8: Following a review of demand and capacity data, the practice identified they were unable to differentiate encounters and work undertaken by different job roles, especially new from the Additional Roles Reimbursement Scheme (ARRS).

SMART aim: To improve consistency of recording job roles to be able to differentiate encounters and work undertaken by different members of the primary care team.

Actions:

- PCN or practice team reviews job roles currently used to add for clinical and administrative team members on to the electronic medical record systems e.g. EMIS or System1
- Agree standard way of adding roles on to the electronic medical record system

- Re-audit after three months to check that agreed job roles are being used consistently across the team

Practices should choose their own quality improvement activities and set their own targets for improvement based on their baseline audit or search results. These should be challenging but realistic. Appendix 2 of the London General Practice Access Manual provides suggested improvement projects.

Targets/ambitions should be validated by network peers as part of the initial network review meeting. Incremental measures of improvement are recommended. Practices should aim to find a way to ensure improvement is continuous and that quality improvement around optimising access to general practice becomes routine. This should include a review and evaluation of the measures implemented as a result of the initial plan.

3. Implementing the plan

Practices should implement the improvement plan they have developed to support the objectives they have identified. It is recommended that these plans and associated improvement activities should involve the whole practice team and practices are encouraged to engage with colleagues outside the practice, where practicable, for example patient support groups, family carer groups and specialist third sector organisations.

4. Primary Care Network peer review meetings

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

The peer review group will usually be the Primary Care Network of which the practice is a member. Where the practice is not part of a network their peer review group should be agreed with the commissioner.

The Network Clinical Lead should choose a suitable facilitator to support sharing of learning and quality improvement. For example, this could be the Network Clinical Lead, another network clinician, a practice manager, or alternatively someone external. A record of attendance should be kept, and it is recommended that the Network Clinical Lead and Network Health Inequalities Lead attend, irrespective of who facilitates the meetings.

It is for the network to determine the timing of these meetings, but it is recommended that the first meeting takes place early in the QI activity at the stage of deciding on what quality improvement activities to undertake and the second towards the end to share outcomes and learning from these activities.

Possible discussion points for PCN peer review meetings include:

- Sharing the outputs of work to understand demand and capacity.
- Has each practice set a clear, challenging but realistic target for improvement?
- What ideas for change are practices considering and how this fits in to wider PCN objectives?
- How the practice is co-producing changes with patients and carers.
- How are practices ensuring the whole practice team are involved?
- How are practices engaging with other services including community pharmacy, the voluntary and community sector and community and secondary care?

5. Reporting and verification

The contractor must complete the QI monitoring template in relation to this module and self-declare that they have completed the activity described in their QI plan. The contractor will also self-declare that they have attended a minimum of two peer review meetings (either in person, where appropriate, or virtually) as described above, unless there are exceptional and unforeseen circumstances which impact on a contractor's ability to participate. In these circumstances 'contractors are expected to make efforts to ensure alternative participation in peer review.

Verification - Commissioners may require contractors to provide a copy of the QI monitoring template as written evidence that the quality improvement activity has been undertaken. Commissioners may require a written record of attendance at the peer review meetings. If a contractor has been unable to attend a meeting due to exceptional circumstances, then they will need to demonstrate other active engagement in network peer learning and review.

We recommend practices include their QI work in any inspections by the Care Quality Commission to demonstrate a visible and consistent approach to quality improvement.

Resources are available to support available from www.england.nhs.uk/gp/investment/gp-contract/

6. Reporting Template

It is anticipated that the responses noted here should total a maximum of 2 A4 sides in Arial font size 11.

Practice name and ODS code
What area of practice did the practice identify for quality improvement?
What was the defined “Smart Aim” of your quality improvement work?
What were the changes you tested?
What changes have been adopted?
How will these changes be sustained in the future?
What measures/indicators did you use to track your improvement?
Did you observe improvements in relation to these measures/indicators? Please provide details of any improvements achieved.

How did the network peer support meetings and patient participation influence the practice's QI plans on optimising access?
Optional: We would be very grateful if you would consider sharing your improvement project as an example of good practice. If you would be willing to do this, please upload it to the Qof QI case studies - Primary Care Improvement CONNECT - FutureNHS Collaboration Platform

Section 6: Personalised care adjustment

As of 1 April 2019, exception reporting is being replaced with a Personalised Care Adjustment (PCA). This will allow practices to differentiate between the following reasons for adjusting care and removing a patient from the indicator denominator:

1. *Unsuitability* for the patient, e.g. because of medicine intolerance or allergy, or contra-indicated polypharmacy;
2. *Patient choice*, following a shared-decision making conversation;
3. The patient *did not respond* to offers of care – recording of this will change to capture actual invitations sent to patients;
4. The specific service is *not available* (in relation to a limited number of indicators only); or
5. *Newly diagnosed or newly registered* patients, as per existing rules.

As with exception reporting applying a PCA to the patient record will remove that patient from an indicator denominator if the QOF defined intervention has not been delivered. It will not result in patients being removed from the disease register or other target population.

This mechanism differs from ‘exclusions ’which refer to patients on a particular clinical register who are not included in an indicator denominator for definitional reasons. For example, an indicator (and therefore the denominator) may refer only to patients of a specific age group, patients with a specific status (e.g. those who smoke), or patients with a specific length of diagnosis, within the register for that clinical area.

Principles

When considering whether a PCA applies to an individual patient practices are reminded that:

- The duty of care remains for all patients,
- The decision to apply a personalised care adjustment should be based on clinical judgement, informed by patient preferences and underpinned by shared decision-making principles, with clear and auditable reasons coded or entered in free text on the patient record
- There should be no blanket personalised care adjustments: the relevant issues with each patient should be considered by the clinician at each level of the clinical indicator set and this decision reviewed on a regular basis.

In each case where a personalised care adjustment is applied then in addition to what needs to be reported for payment purposes (in accordance with the Business Rules), the contractor should also ensure that the reason for the adjustment is fully recorded in a way that can facilitate both safe and effective patient care and audit of the patient record. For example, where a patient has not tolerated medication, the

nature of the contraindication should be recorded in the patient's record as well as a code to indicate intolerance.

Criteria for the personalised care adjustment

Personalisation of care can occur for the following reasons which are listed in the order in which they will be extracted in the Business Rules:

1. The investigative service or secondary care service is unavailable (where relevant to the indicator)
2. Intervention described in the indicator is clinically unsuitable
3. The patient has chosen not to receive the intervention described in the indicator
4. The patient has not responded to invitations for the intervention described in the indicator (a minimum of two invitations for the intervention in the preceding 12 months, except for the cervical screening indicators where women should receive a total of three invitations for screening)
5. The patient has registered with the practice or has been newly diagnosed with the condition of interest in the preceding 3 months and has not received the defined clinical measurements e.g. blood pressure measurement
6. The patient has registered with the practice or has been newly diagnosed with the condition of interest in the preceding 9 months and has not achieved the defined clinical standards e.g. blood pressure control within target levels.

It is recognised that patients may meet more than one of these criteria and in these circumstances all reasons for personalisation should be recorded in the patient's record to facilitate safe and effective patient care. However, as a patient can only be acknowledged as having a personalised care adjustment once within the Business Rules for a given indicator, they will be allocated to the first criterion they meet in the hierarchy listed above. For example, where a patient is recorded as having registered with the practice in the preceding 3 months and has also chosen not to receive the intervention described in the indicator they would be identified in the Business Rules as having chosen not to receive the care.

The hierarchy listed above seeks to prioritise clinical judgement and patient choice over other criteria. Applying this hierarchy consistently in the Business Rules in conjunction with the recording changes described below will support better attribution of the reason for care being personalised, allowing for more meaningful conversations between clinicians, commissioners and regulators.

Interpretation and recording of the personalised care adjustment

The interpretation of these categories and how they should be recorded is detailed further below.

The investigative service or secondary care service is unavailable

This care adjustment will apply only to the following indicators: HF005, AST006, COPD008 and DM014.

Where one of these services is unavailable this should be recorded using specific codes which state that the service is unavailable. The contractor is expected to explore fully with their CCG, if a suitable investigative or secondary service could be commissioned for the patient prior to entering a service unavailable code in the patient record.

The frequency with which service unavailable codes should be added to the patient record is noted below and may vary between indicators. Some codes may need to be entered annually whereas others may only need to be entered once in the relevant timeframe stated in the indicator.

Table 2: Frequency of data entry

Indicator ID	Service unavailable may be recorded
HF005	Within 6 months of diagnosis of heart failure
AST006	Within 6 months of diagnosis of asthma
COPD008	Required each year the patient becomes eligible for pulmonary rehabilitation
DM014	Within 279 days of diagnosis of diabetes

Intervention described in the indicator is clinically unsuitable

We envisage this being the main reason for personalisation of care, recognising the importance of clinical judgement in determining the applicability of guideline recommendations to individual patients.

This category encapsulates the historical exception reporting criteria of 1) patients for whom it is not appropriate to review their chronic disease parameters due to particular circumstances e.g. receiving end of life care, 2) those who are on maximal tolerated doses of medication, 3) those who have an allergy, contraindication or adverse reaction to medication, 4) those who have not tolerated medications and 5) where the patient has a supervening condition which would make treatment of their condition inappropriate.

This criterion will be supported by both generic ‘patient unsuitable ’codes which will apply to all indicators in the clinical area except for indicators VI001, VI002 and VI003) and more specific codes which can be attributed to single indicators. Indicators in the Vaccination and Immunisation domain will be supported by specific codes for clinical unsuitability for a vaccination. Over time, more specific codes will

be introduced which define the clinical reasons which might make the intervention clinically unsuitable for an individual patient.

Codes which indicate ongoing and permanent reasons for personalisation of care such as allergies to specified medication may be entered once in the medical record. Other codes will need to be recorded on an annual basis following an individual patient review of the applicability of the intervention described in the indicator.

It is not acceptable to exclude all patients who are under the care of a consultant. Each case needs to be carefully considered and all reasonable efforts made to provide optimal care.

Even when a patient is under the care of a consultant only, the contractor should ensure it has evidence that all the requirements of the contract have been carried out. If this evidence is not available, the contractor should assume that the action has not been carried out and either fulfil the requirements of the relevant indicator(s) or obtain evidence from secondary care that the particular test/check has been carried out. Where the secondary care clinician, in agreement with the primary care clinician, has exercised clinical judgement and decided further action or testing is inappropriate, this should be noted in the patient record. A personalised care adjustment may them be applied.

The patient has chosen not to receive the intervention described in the indicator

This criterion requires that there has been a personal contact or a discussion recorded in the patient record which ideally notes the reasons for the intervention being declined. This contact may be face-to-face, video conferencing or telephone contact between a health professional and the patient.

This criterion will be supported by both generic ‘informed dissent ’codes which will apply to all indicators in the clinical area and more specific codes which can be attributed to single indicators. Practices are encouraged to use more specific codes where they are available.

The decision to decline a QOF intervention should be reviewed with the patient on an annual basis and recorded annually if necessary. The exceptions to this are indicators CS005 and CS006 where the choice not to receive the intervention need only be entered once during the time-period stated in the indicator. However, as noted in the underpinning principles, good practice would be to revisit this decision on a regular basis. Women who choose to withdraw from the cervical screening call/recall will receive no further offers of screening from the central screening service.

The patient has not responded to invitations for the intervention described in the indicator

To be removed from an indicator denominator using this criterion patients must have been sent a minimum of **two** invitations for QOF care at two unique time points in the QOF year i.e. 1 April to 31 March separated by a minimum of seven calendar days.

The exceptions to this are indicators CS005 and CS006 where the patient should have been sent a minimum of **three** invitations at three unique time points during the timeframe stipulated in the indicator. However, care should continue to be offered on an opportunistic basis where appropriate.

General standards and recording requirements for invitations

Many different methods of communication are already available to invite patients for QOF care and these are likely to expand with the ongoing development of digital technology. The NHS also has a legal duty to ensure that patients who have a disability, impairment or sensory loss get information that they can access and understand as set out in the Accessible Information Standard.[148] The first step to making an effective invitation for care therefore is that it is made in a manner which is accessible to the patient. Therefore, practices should prospectively and opportunistically record individual patients preferred methods of communication, for example at the time of the next patient contact. Where a preferred contact method is recorded this would be used to make the first invitation for care. The second invitation may be via any method.

All invitations should be personalised to the patient i.e. use their name and specify what they are being invited for. Where invitations are being sent via letter or email these should also include information for the patient as to why this care is being offered and its importance for their health care.

Invitations should be coded at the time they are sent to the patient. For data extraction purposes, there should be a minimum of seven calendar days between each invitation, but practices should use their judgement in determining the optimal spacing between invitations for their practice population. A longer period may be more appropriate. Codes currently exist to indicate the communication method used to make the invitation and that the patients preferred method was used. Both will be acceptable for QOF purposes.

Patients should be sent a minimum of two invitations for care within the QOF year i.e. 1 April – 31 March. If these invitations are correctly coded then they will be identified through the business rules and there will be no need to add additional codes at year-end to indicate that a patient has not responded to these invitations.

As at present, generic invitations such as messages added to the right-hand side of prescriptions or notices in the waiting room inviting groups of patients to attend clinics or make appointments will not be acceptable.

Invitations for cervical screening

As noted above, the requirement for women to be invited on three separate occasions will continue in line with national screening programme requirements. Therefore:

[148] https://www.england.nhs.uk/ourwork/accessibleinfo/

- In those areas where the first two invitations are sent via the central screening service, then contractors are responsible for offering the third invitation, or
- Where the central screening service sends out only one letter, then contractors are responsible for offering the second and third invitation.
- Where contractors have opted to run their own call/recall system then they are responsible for making all three invitations.

Where a woman does not respond to these three invitations then contractors will need to code that this has been the case.. Each invitation should be recorded in the patient record as evidence of these may be required for assessment and audit purposes.

Women may choose to withdraw from the national screening programme. This should be undertaken with caution as women who withdraw from cervical screening call/recall will receive no further offers of screening from the central service. Where women actively decline cervical screening, this should be recorded as such.

The patient has registered with the practice or been newly diagnosed with the condition in the last 3 months of the QOF year and has not received defined clinical measurements

Where a patient newly registers with a practice or is newly diagnosed with a clinical condition in the last three months of the QOF year (1 January – 31 March) this criterion applies automatically, unless the contractor has recorded the defined clinical measurements within the timeframe for the indicator. This is because achievement automatically over-rides any PCA.

The patient has registered with the practice or has been newly diagnosed with the condition in the last 9 months of the QOF year and has not achieved defined clinical standards

Where a patient newly registers with a practice or is newly diagnosed with a clinical condition in the last nine months of the QOF year (1 July – 31 March) this criterion applies automatically, unless the contractor has achieved the defined clinical standards within the timeframe for the indicator. This is because achievement automatically over-rides any PCA.

Section 7: Indicators no longer in QOF (INLIQ)

There are no changes to the INLIQ extraction from 1 April 2022. The indicators included in INLIQ in 2022/23 are detailed below.

Indicator ID	Indicator description
CHD003	The percentage of patients with coronary heart disease whose last measured cholesterol (measured in the preceding 12 months) is 5 mmol/l or less
CKD002	The percentage of patients on the CKD register in whom the last blood pressure reading (measured in the preceding 12 months) is 140/85 mmHg or less
CKD004	The percentage of patients on the CKD register whose notes have a record of a urine albumin:creatinine ratio (or protein:creatinine ratio) test in the preceding 12 months
NM84	The percentage of patients on the CKD register with hypertension and proteinuria who are currently treated with renin-angiotensin system antagonists
CVD-PP002	The percentage of patients diagnosed with hypertension (diagnosed after or on 1 April 2009) who are given lifestyle advice in the preceding 12 months for: smoking cessation, safe alcohol consumption and healthy diet
DM005	The percentage of patients with diabetes, on the register, who have a record of an albumin:creatinine ratio test in the preceding 12 months
DM011	The percentage of patients with diabetes, on the register, who have a record of retinal screening in the preceding 12 months
EP002	The percentage of patients 18 or over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the preceding 12 months
EP003	The percentage of women aged 18 or over and who have not attained the age of 55 who are taking antiepileptic drugs who have a record of information and counselling about contraception, conception and pregnancy in the preceding 12 months
LD002	The percentage of patients on the learning disability register with Down's syndrome aged 18 or over who have a record of blood TSH in the preceding 12 months

MH004	The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol:hdl ratio in the preceding 12 months
MH007	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months
MH008	The percentage of women aged 25 or over and who have not attained the age of 65 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years.
PAD002	The percentage of patients with peripheral arterial disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less.
PAD003	The percentage of patients with peripheral arterial disease in whom the last measured total cholesterol (measured in the preceding 12 months) I 5 mmol/l or less
PAD004	The percentage of patients with peripheral arterial disease with a record in the preceding 12 months that aspirin or an alternative anti-platelet is being taken.
RA003	The percentage of patients with rheumatoid arthritis aged 30 or over and who have not attained the age of 85 who have had a cardiovascular risk assessment using a CVD risk assessment tool adjusted for RA in the preceding 12 months
RA004	The percentage of patients aged 50 or over and who have not attained the age of 91 with rheumatoid arthritis who have had an assessment of fracture risk using a risk assessment toll adjusted for RA in the preceding 24 months
SMOK001	The percentage of patients aged 15 or over whose notes record smoking status in the preceding 24 months
STIA005	The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA whose last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less
THY001	The contractor establishes and maintains a register of patients with hypothyroidism who are currently treated with levothyroxine
THY002	The percentage of patients with hypothyroidism, on the register, with thyroid function tests recorded in the preceding 12 months

Section 8: Glossary of acronyms

Abbreviation	Definition
A&E	Accident and Emergency
ABPM	Ambulatory Blood Pressure Monitoring
ACE-Inhibitor or ACE-I	Angiotensin Converting Enzyme Inhibitor
ACR	Albumin Creatinine Ratio
AF	Atrial Fibrillation
APDF	Adjusted Practice Disease Factor
ARB	Angiotensin Receptor Blocker
AST	Asthma
ATS/ERS	American Thoracic Society/European Respiratory Society
BMD	Bone Mass Density
BMI	Body Mass Index
BMA	British Medical Association
BMJ	British Medical Journal
BNF	British National Formulary
BP	Blood Pressure
BTS	British Thoracic Society
CABG	Coronary Artery Bypass Grafting
CAN	Cancer
CAT	COPD Assessment Test
CCG	Clinical Commissioning Group

Abbreviation	Definition
CG	Clinical guideline (NICE)
CHD	Coronary Heart Disease
$CHADS_2$	Congestive (HF) Hypertension Age (75 or over) Diabetes Stroke
CHA_2DS_2-VASc	Congestive (HF) Hypertension Age (75 or over) Diabetes Stroke (prior stroke) Vascular Disease (peripheral artery disease) Age (65–74 years) Sex Category (i.e. female)
CKD	Chronic Kidney Disease
CMO	Chief Medical Officer
COPD	Chronic Obstructive Pulmonary Disease
CPA	Care Programme Approach
CQRS	Calculating Quality Reporting Service
CRP	C-Reactive Protein
CS	Cervical Screening
CVD	Cardiovascular Disease
CVD-PP	CVD Primary Prevention
DEM	Dementia
DEP	Depression
DM	Diabetes Mellitus
DMARD	Disease Modifying Anti-Rheumatic Drugs
DXA	Dual-Energy X-ray Absorptiometry
ED	Erectile Dysfunction
eGFR	Estimated Glomerular Filtration Rate
EOLC	End of Life Care

Abbreviation	Definition
EP	Epilepsy
ES	Enhanced Service
ESR	Erythrocyte Sedimentation Rate
FEV_1	Forced Expiratory Volume in One Second
FVC	Forced Vital Capacity
GFR	Glomerular Filtration Rate
GMC	General Medical Council
GMS	General Medical Services
GOLD	The Global Initiative for Chronic Obstructive Lung Disease
GP	General Practitioner
GPC England	General Practitioners Committee England
GPES	General Practice Extraction Service
GSF	Gold Standards Framework
HbA1c	Glycated Haemoglobin
HBPM	Home Blood Pressure Monitoring
HF	Heart Failure
HYP	Hypertension
IFCC	International Federation of Clinical Chemistry and Laboratory Medicine
INLIQ	Indicators no longer in in QOF
IQ	Intelligence Quotient
JCVI	Joint Committee on Vaccination and Immunisation

Abbreviation	Definition
LD	Learning Disabilities
LDL	Low Density Lipoprotein
LVSD	Left Ventricular Systolic Dysfunction
MDT	Multi-disciplinary team
MH	Mental Health
MI	Myocardial Infarction
mmHg	Millimetres of Mercury
mmol/l	Millimoles per Litre
MRC	Medical Research Council
NCSI	National Cancer Survivorship Initiative
NDH	Non-Diabetic Hyperglycaemia
NG	NICE guideline
NHS	National Health Service
NHS CB	NHS Commissioning Board (NHS England)
NICE	National Institute for Health and Care Excellence
NRT	Nicotine Replacement Therapy
NSF	National Service Framework
OB	Obesity
OGTT	Oral Glucose Tolerance Test
ONS	Office for National Statistics
OST	Osteoporosis
PAD	Peripheral Arterial Disease

Abbreviation	Definition
PC	Palliative Care
PCA	Personalised Care Adjustment
PCRJ	Primary Care Respiratory Journal
PEF	Peak Expiratory Flow
PH	Public health
PPI	Proton pump inhibitor
PVD	Peripheral Vascular Disease
QI	Quality Improvement
QOF	Quality and Outcomes Framework
QS	Quality standard (NICE)
RA	Rheumatoid Arthritis
RCGP	Royal College of General Practitioners
RCP	Royal College of Physicians
RCN	Royal College of Nurses
SFE	Statement of Financial Entitlements
SMOK	Smoking
SPICT	Supportive and Palliative Care Indicators Tool
SWOT analysis	Strengths, weaknesses, opportunities and threats analysis
STIA	Stroke or Transient Ischemic Attack
TA	Technology appraisal (NICE)
TIA	Transient Ischemic Attack

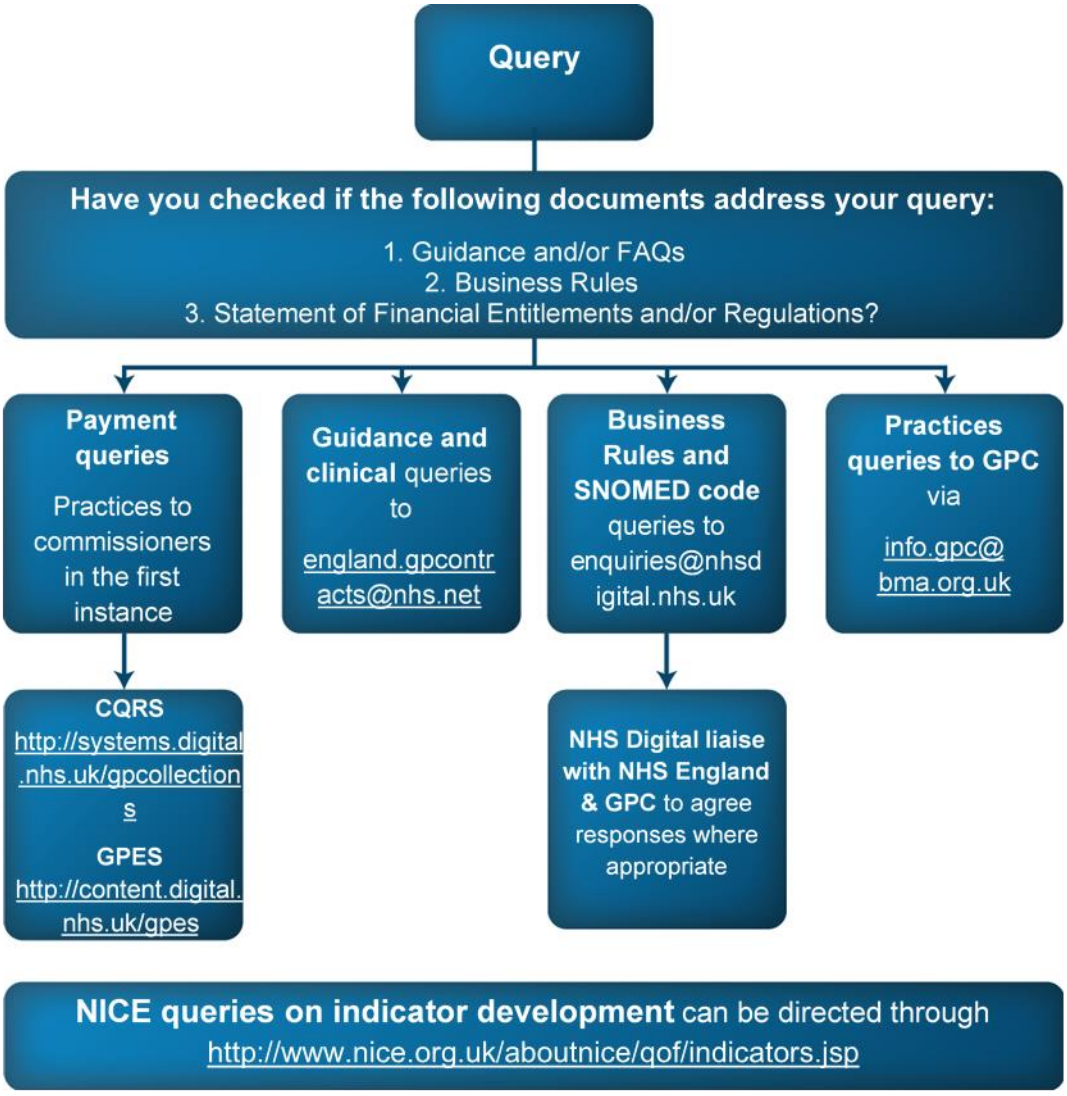
Abbreviation	Definition
TSH	Thyroid Stimulating Hormone
UK	United Kingdom
US	United States
WHO	World Health Organisation

Section 9: Queries

Queries fall into three main categories:

1. Those which can be resolved by referring to guidance and/or FAQs
2. Those requiring interpretation of the guidance or Business Rules[149]
3. Those not anticipated in guidance.

Queries may incorporate one or more of the following areas: Business Rules, coding, payment, CQRS, GPES, and clinical or policy issues. The recipient of the query will liaise with other relevant parties in order to respond and where necessary the query will be redirected.



[149] NHS Digital. http://content.digital.nhs.uk/qofesextractspecs

NHS England and NHS Improvement
www.england.nhs.uk

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