

# Quality and outcomes framework

## Guidance – Updated August 2004

### Section 1: Principles

The following principles relating to the Quality and Outcomes Framework were agreed by the negotiators.

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

### Section 2: Clinical Indicators

#### 1. General format

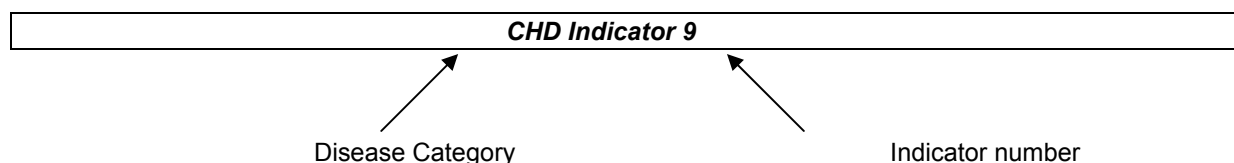
The clinical indicators are organised by disease category. The disease categories have been selected for the following reasons:

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

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

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

Indicators across all disease categories are numbered. In the guidance they are prefixed by the disease category to which they belong and contained in a box eg



A number of patients will have multiple diseases: for instance, a significant number of patients with diabetes will also have coronary heart disease (CHD) or hypertension. While it could be argued that the quality framework fragments the care that one individual receives, in complex patients important process issues can be missed during follow-up. The separation of disease categories in the Quality and Outcomes Framework will allow clinicians to check that, for example, the hypertensive diabetic with developing CHD continues to have his or her diabetes monitored while the clinician focuses on the developing CHD.

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

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

## **1.1 Rationale**

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

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

The indicators are not intended to cover all the process issues or outcomes indicators for each disease category. The indicator sets are designed to encourage more structured care of patients with chronic diseases. Inevitably, in order to meet the requirement that indicators should be retrievable from GP computer systems, a significant number have been discarded which are not easily recorded in an IT format. In some instances, for example monitoring lifestyle factors in CHD, one indicator has been selected to reflect the care being undertaken by that practice.

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

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

## **1.2 Read Codes**

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

## **1.3 Reporting and Verification**

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

It is hoped that all reporting will be possible through the use of GP clinical systems and that practices will be able to run a report annually which can be submitted to the PCO. Separate guidance has been

produced on the electronic queries which can be used to report on the Quality and Outcomes Framework. This can be found at the following location:

[http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PrimaryCare/PrimaryCareContracting/PrimaryCareContractingArticle/fs/en?CONT\\_ID=4078648&chk=/FWc3u](http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PrimaryCare/PrimaryCareContracting/PrimaryCareContractingArticle/fs/en?CONT_ID=4078648&chk=/FWc3u)

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

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

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

## 2. Exception reporting

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

The following criteria have been agreed for exception reporting:

- A) patients who have been recorded as refusing to attend review who have been invited on at least three occasions during the preceding twelve months
- B) patients for whom it is not appropriate to review the chronic disease parameters due to particular circumstances eg terminal illness, extreme frailty
- C) patients newly diagnosed within the practice or who have recently registered with the practice, who should have measurements made within three months and delivery of clinical standards within nine months eg blood pressure or cholesterol measurements within target levels
- D) patients who are on maximum tolerated doses of medication whose levels remain sub-optimal
- E) patients for whom prescribing a medication is not clinically appropriate eg those who have an allergy, another contraindication or have experienced an adverse reaction
- F) where a patient has not tolerated medication
- G) where a patient does not agree to investigation or treatment (informed dissent), and this has been recorded in their medical records
- H) where the patient has a supervening condition which makes treatment of their condition inappropriate eg cholesterol reduction where the patient has liver disease
- I) where an investigative service or secondary care service is unavailable.

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

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

In some instances, a patient may have been referred to a specialist with the expectation that a test or investigation would be carried out. Where this has not been done (eg a specialist has ordered an alternative test to an echocardiogram for a patient with heart failure), that patient would be exception-reported (as in I above). In other cases, eg a diabetic with a hospital summary of an annual review which had no record of fundoscopy, it would be the GP's overall responsibility to ensure that appropriate care had been given.

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

### **3. Disease registers**

An important feature of the Quality and Outcomes Framework is the establishment of disease registers. While it is recognised that these may not be one hundred per cent accurate, it is the responsibility of the practice to demonstrate that it has systems in place to maintain a high quality register. Verification visits may involve asking how the practice constructed the register and how the register is maintained. PCOs will compare the reported prevalence with the expected prevalence. This is a fairly blunt instrument and there are likely to be good reasons for variations but it is anticipated these will be discussed with practices. An explanation on how points are calculated and how prevalence will be applied can be found in part 2 of the Statement of Financial Entitlements for 2004/05.

## Summary of all Clinical Indicators

### Secondary Prevention in Coronary Heart Disease (CHD)

Indicator	Points	Payment Stages
<b>Records</b>		
CHD 1. The practice can produce a register of patients with coronary heart disease	6	
<b>Diagnosis and initial management</b>		
CHD 2. The percentage of patients with newly diagnosed angina (diagnosed after 1 April 2003) who are referred for exercise testing and/or specialist assessment	7	25-90%
<b>Ongoing Management</b>		
CHD 3. The percentage of patients with coronary heart disease whose notes record smoking status in the past 15 months, except those who have never smoked where smoking status need be recorded only once since diagnosis	7	25-90%
CHD 4. The percentage of patients with coronary heart disease who smoke, whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered within the last 15 months	4	25-90%
CHD 5. The percentage of patients with coronary heart disease whose notes have a record of blood pressure in the previous 15 months	7	25-90%
CHD 6. The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the last 15 months) is 150/90 or less	19	25-70%
CHD 7. The percentage of patients with coronary heart disease whose notes have a record of total cholesterol in the previous 15 months	7	25-90%
CHD 8. The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in last 15 months) is 5 mmol/l or less	16	25-60%
CHD 9. The percentage of patients with coronary heart disease with a record in the last 15 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken (unless a contraindication or side-effects are recorded)	7	25-90%
CHD 10. The percentage of patients with coronary heart disease who are currently treated with a beta blocker (unless a contraindication or side-effects are recorded)	7	25-50%
CHD 11. The percentage of patients with a history of myocardial infarction (diagnosed after 1 April 2003) who are currently treated with an ACE inhibitor or angiotensin II antagonist	7	25-70%
CHD 12. The percentage of patients with coronary heart disease who have a record of influenza immunisation in the preceding 1 September to 31 March	7	25-85%
<b>Sub Set – Left Ventricular Dysfunction</b>		
<b>Records</b>		
LVD 1. The practice can produce a register of patients with CHD and left ventricular dysfunction	4	
<b>Diagnosis and initial management</b>		
LVD 2. The percentage of patients with a diagnosis of CHD and left ventricular dysfunction (diagnosed after 1 April 2003) which has been confirmed by an echocardiogram	6	25-90%

Indicator	Points	Payment Stages
<b>Ongoing Management</b>		
LVD 3. The percentage of patients with a diagnosis of CHD and left ventricular dysfunction who are currently treated with ACE inhibitors (or A2 antagonists)	10	25-70%

## Stroke and Transient Ischaemic Attacks

Indicator	Points	Payment Stages
<b>Records</b>		
STROKE 1. The practice can produce a register of patients with Stroke or TIA	4	
STROKE 2. The percentage of new patients with presumptive stroke (presenting after 1 April 2003) who have been referred for confirmation of the diagnosis by CT or MRI scan	2	25-80%
<b>Ongoing Management</b>		
STROKE 3. The percentage of patients with TIA or stroke who have a record of smoking status in the last 15 months, except those who have never smoked where smoking status need be recorded only once since diagnosis	3	25-90%
STROKE 4. The percentage of patients with a history of TIA or stroke who smoke and whose notes contain a record that smoking cessation advice or referral to a specialist service, if available, has been offered in the last 15 months	2	25-70%
STROKE 5. The percentage of patients with TIA or stroke who have a record of blood pressure in the notes in the preceding 15 months	2	25-90%
STROKE 6. The percentage of patients with a history of TIA or stroke in whom the last blood pressure reading (measured in last 15 months) is 150/90 or less	5	25-70%
STROKE 7. The percentage of patients with TIA or stroke who have a record of total cholesterol in the last 15 months	2	25-90%
STROKE 8. The percentage of patients with TIA or stroke whose last measured total cholesterol (measured in last 15 months) is 5 mmol/l or less	5	25-60%
STROKE 9. The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken (unless a contraindication or side-effects are recorded)	4	25-90%
STROKE 10. The percentage of patients with TIA or stroke who have had influenza immunisation in the preceding 1 September to 31 March	2	25-85%

## Hypertension

Indicator	Points	Payment Stages
<b>Records</b>		
BP 1. The practice can produce a register of patients with established hypertension	9	
<b>Diagnosis and initial management</b>		
BP 2. The percentage of patients with hypertension whose notes record smoking status at least once since diagnosis	10	25-90%
BP 3. The percentage of patients with hypertension who smoke, whose notes contain a record that smoking cessation advice or referral to a specialist service, if available, has been offered at least once	10	25-90%
<b>Ongoing Management</b>		
BP 4. The percentage of patients with hypertension in whom there is a record of the blood pressure in the past 9 months	20	25-90%
BP 5. The percentage of patients with hypertension in whom the last blood pressure (measured in the last 9 months) is 150/90 or less	56	25-70%

## Diabetes Mellitus (Diabetes)

Indicator	Points	Payment Stages
<b>Records</b>		
DM 1. The practice can produce a register of all patients with diabetes mellitus	6	
<b>Ongoing Management</b>		
DM 2. The percentage of patients with diabetes whose notes record BMI in the previous 15 months	3	25-90%
DM 3. The percentage of patients with diabetes in whom there is a record of smoking status in the previous 15 months, except those who have never smoked where smoking status need be recorded only once since diagnosis	3	25-90%
DM 4. The percentage of patients with diabetes who smoke and whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered in the last 15 months	5	25-90%
DM 5. The percentage of diabetic patients who have a record of HbA1c or equivalent in the previous 15 months	3	25-90%
DM 6. The percentage of patients with diabetes in whom the last HbA1C is 7.4 or less (or equivalent test/reference range depending on local laboratory) in last 15 months	16	25-50%
DM 7. The percentage of patients with diabetes in whom the last HbA1C is 10 or less (or equivalent test/reference range depending on local laboratory) in last 15 months	11	25-85%
DM 8. The percentage of patients with diabetes who have a record of retinal screening in the previous 15 months	5	25-90%
DM 9. The percentage of patients with diabetes with a record of the presence or absence of peripheral pulses in the previous 15 months	3	25-90%
DM 10. The percentage of patients with diabetes with a record of neuropathy testing in the previous 15 months	3	25-90%
DM 11. The percentage of patients with diabetes who have a record of the blood pressure in the past 15 months	3	25-90%
DM 12. The percentage of patients with diabetes in whom the last blood pressure is 145/85 or less	17	25-55%
DM 13. The percentage of patients with diabetes who have a record of micro-albuminuria testing in the previous 15 months (exception reporting for patients with proteinuria)	3	25-90%
DM 14. The percentage of patients with diabetes who have a record of serum creatinine testing in the previous 15 months	3	25-90%
DM 15. The percentage of patients with diabetes with a diagnosis of proteinuria or micro-albuminuria who are treated with ACE inhibitors (or A2 antagonists)	3	25-70%
DM 16. The percentage of patients with diabetes who have a record of total cholesterol in the previous 15 months	3	25-90%
DM 17. The percentage of patients with diabetes whose last measured total cholesterol within the previous 15 months is 5mmol/l or less	6	25-60%
DM 18. The percentage of patients with diabetes who have had influenza immunisation in the preceding 1 September to 31 March	3	25-85%

## Chronic Obstructive Pulmonary Disease (COPD)

Indicator	Points	Payment Stages
<b>Records</b>		
COPD 1. The practice can produce a register of patients with COPD	5	
<b>Initial diagnosis</b>		
COPD 2. The percentage of patients in whom diagnosis has been confirmed by spirometry including reversibility testing for newly diagnosed patients with effect from 1 April 2003	5	25-90%
COPD 3. The percentage of all patients with COPD in whom diagnosis has been confirmed by spirometry including reversibility testing	5	25-90%
<b>Ongoing management</b>		
COPD 4. The percentage of patients with COPD in whom there is a record of smoking status in the previous 15 months, except those who have never smoked where smoking status need be recorded only once since diagnosis	6	25-90%
COPD 5. The percentage of patients with COPD who smoke, whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered in the past 15 months	6	25-90%
COPD 6. The percentage of patients with COPD with a record of FeV1 in the previous 27 months	6	25-70%
COPD 7. The percentage of patients with COPD receiving inhaled treatment in whom there is a record that inhaler technique has been checked in the preceding 27 months	6	25-90%
COPD 8. The percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March	6	25-85%

## Epilepsy

Indicator	Points	Payment Stages
<b>Records</b>		
EPILEPSY 1. The practice can produce a register of patients receiving drug treatment for epilepsy	2	
<b>Ongoing Management</b>		
EPILEPSY 2. The percentage of patients aged 16 and over on drug treatment for epilepsy who have a record of seizure frequency in the previous 15 months	4	25-90%
EPILEPSY 3. The percentage of patients aged 16 and over on drug treatment for epilepsy who have a record of medication review in the previous 15 months	4	25-90%
EPILEPSY 4. The percentage of patients aged 16 and over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the last 15 months	6	25-70%

## Hypothyroidism

Indicator	Points	Payment stages
<b>Records</b>		
THYROID 1. The practice can produce a register of patients with hypothyroidism	2	
<b>Indicator</b>	<b>Points</b>	<b>Payment Stages</b>
<b>Ongoing Management</b>		
THYROID 2. The percentage of patients with hypothyroidism with thyroid function tests recorded in the previous 15 months	6	25-90%

## Cancer

Indicator	Points	Payment stage
<b>Records</b>		
CANCER 1. The practice can produce a register of all cancer patients diagnosed after 1 April 2003	6	
<b>Ongoing Management</b>		
CANCER 2. The percentage of patients with cancer diagnosed from 1 April 2003 with a review by the practice recorded within six months of confirmed diagnosis. This should include an assessment of support needs, if any, and a review of co-ordination arrangements with secondary care	6	25-90%

## Mental Health (MH)

Indicator	Points	Payment stages
<b>Records</b>		
MH 1. The practice can produce a register of people with severe long-term mental health problems who require and have agreed to regular follow-up	7	
<b>Ongoing management</b>		
MH 2. The percentage of patients with severe long-term mental health problems with a review recorded in the preceding 15 months. This review includes a check on the accuracy of prescribed medication, a review of physical health and a review of co-ordination arrangements with secondary care	23	25-90%
MH 3. The percentage of patients on lithium therapy with a record of lithium levels checked within the previous 6 months	3	25-90%
MH 4. The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 15 months	3	25-90%
MH 5. The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the previous 6 months	5	25-70%

## Asthma

Indicator	Points	Payment stages
<b>Records</b>		
ASTHMA 1. The practice can produce a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the last twelve months	7	
<b>Initial Management</b>		
ASTHMA 2. The percentage of patients aged eight and over diagnosed as having asthma from 1 April 2003 where the diagnosis has been confirmed by spirometry or peak flow measurement	15	25-70%
<b>Indicator</b>	<b>Points</b>	<b>Payment Stages</b>
<b>Ongoing management</b>		
ASTHMA 3. The percentage of patients with asthma between the ages of 14 and 19 in whom there is a record of smoking status in the previous 15 months	6	25-70%
ASTHMA 4. The percentage of patients aged 20 and over with asthma whose notes record smoking status in the past 15 months, except those who have never smoked where smoking status need be recorded only once since diagnosis	6	25-70%
ASTHMA 5. The percentage of patients with asthma who smoke, and whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered within the last 15 months	6	25-70%
ASTHMA 6. The percentage of patients with asthma who have had an asthma review in the last 15 months	20	25-70%
ASTHMA 7. The percentage of patients aged 16 and over with asthma who have had influenza immunisation in the preceding 1 September to 31 March	12	25-70%

## Details of the rationale for indicators, and proposed methods of data collection and monitoring

### Secondary Prevention in Coronary Heart Disease (CHD)

Indicator	Points	Payment Stages
<b>Records</b>		
CHD 1. The practice can produce a register of patients with coronary heart disease	6	
<b>Diagnosis and initial management</b>		
CHD 2. The percentage of patients with newly diagnosed angina (diagnosed after 1 April 2003) who are referred for exercise testing and/or specialist assessment	7	25-90%
<b>Ongoing Management</b>		
CHD 3. The percentage of patients with coronary heart disease whose notes record smoking status in the past 15 months, except those who have never smoked where smoking status need be recorded only once since diagnosis	7	25-90%
CHD 4. The percentage of patients with coronary heart disease who smoke, whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered within the last 15 months	4	25-90%
CHD 5. The percentage of patients with coronary heart disease whose notes have a record of blood pressure in the previous 15 months	7	25-90%
CHD 6. The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the last 15 months) is 150/90 or less	19	25-70%
CHD 7. The percentage of patients with coronary heart disease whose notes have a record of total cholesterol in the previous 15 months	7	25-90%
CHD 8. The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in last 15 months) is 5 mmol/l or less	16	25-60%
CHD 9. The percentage of patients with coronary heart disease with a record in the last 15 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken (unless a contraindication or side-effects are recorded)	7	25-90%
CHD 10. The percentage of patients with coronary heart disease who are currently treated with a beta blocker (unless a contraindication or side-effects are recorded)	7	25-50%
CHD 11. The percentage of patients with a history of myocardial infarction (diagnosed after 1 April 2003) who are currently treated with an ACE inhibitor or Angiotensin II antagonist	7	25-70%
CHD 12. The percentage of patients with coronary heart disease who have a record of influenza immunisation in the preceding 1 September to 31 March	7	25-85%

### CHD - Rationale for Inclusion of Indicator Set

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

## **CHD Indicator 1**

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

### **CHD 1.1 Rationale**

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

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

### **CHD 1.2 Reporting and Verification**

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

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

## **CHD Indicator 2**

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

### **CHD 2.1 Rationale**

Diagnosis of coronary heart disease

The Quality and Outcomes Framework does not specify how the diagnosis of angina is made or confirmed. This will vary from patient to patient, eg clinical history, response to medication, results of investigations, hospital letters etc.

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

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

*Reference Grade B Recommendation SIGN Guideline 51*

Further Information: <http://www.sign.ac.uk/guidelines/fulltext/51/index.html>

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

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

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

Patients should not be referred for an ETT if:

- they are on maximal medical treatment and still have angina symptoms
- the diagnosis of CHD is unlikely (these patients should be referred to a cardiologist)

- they are physically incapable of performing the test
- they have clinical features suggestive of aortic stenosis or cardiomyopathy
- the results of stress testing would not affect management.

*Reference Grade B Recommendation SIGN Guideline 51*

Further Information: <http://www.sign.ac.uk/guidelines/fulltext/51/section2.html>

Specialist Referral:

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

### **CHD 2.2 Reporting and Verification**

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

In verifying that this information has been correctly recorded, a number of approaches could be taken by the Primary Care Organisation:

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

### **CHD Indicator 3**

**The percentage of patients with coronary heart disease whose notes record smoking status in the past 15 months, except those who have never smoked where smoking status need be recorded only once since diagnosis**

### **CHD 3.1 Rationale**

The following modifiable lifestyle factors are known to be associated with an increased risk of coronary heart disease:

- Tobacco smoking
- Excessive alcohol consumption
- Physical inactivity
- Obesity.

*Reference SIGN Guideline 41*

*European Task Force European Society of Cardiology*

Further Information: <http://www.sign.ac.uk/guidelines/fulltext/41/index.html>

Further

[http://www.escardio.org/knowledge/guidelines/CVD\\_Prevention\\_in\\_Clinical\\_Practice.htm](http://www.escardio.org/knowledge/guidelines/CVD_Prevention_in_Clinical_Practice.htm)

Information:

It is anticipated that all these risk factors are likely to be assessed annually, as part of a routine annual assessment. Reporting for the purpose of the contract will focus on smoking status.

It is recognised that lifelong non-smokers are very unlikely to start smoking and indeed find it quite irritating to be asked repeatedly regarding their smoking status. Smoking status for this group of patients need only be recorded once since diagnosis.

### CHD 3.2 Reporting and Verification

The aim of this indicator is to ensure that the smoking status of all patients in the previous year is known, making the assumption that patients who have never smoked will continue not to smoke (in order to avoid keeping asking them).

The numerator of the indicator is the number of CHD patients who have never smoked plus the number who have been recorded as ex- or current smokers in the past 15 months. The denominator is the total number of CHD patients. Thus:

*% with smoking status recorded (among patients with CHD) =*

*[no of never smoked] + [no recorded as ex- or current smokers in past 15 months]*

*\_\_\_\_\_*  
*[number with CHD]*

### CHD Indicator 4

**The percentage of patients with coronary heart disease who smoke, whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered in the last 15 months**

### CHD 4.1 Rationale

There is strong evidence that stopping smoking reduces the risk of myocardial infarction in patients with CHD.

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

*Reference Grade B recommendation SIGN Guidelines 41/51*

Further Information: <http://www.sign.ac.uk/guidelines/fulltext/51/index.html>

Further Information: <http://www.sign.ac.uk/guidelines/fulltext/41/index.html>

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

Further Information: <http://www.nice.org.uk/pdf/NiceNRT39GUIDANCE.pdf>

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

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

## **CHD 4.2 Reporting and Verification**

The practice should report the percentage of patients on the CHD register who are current smokers who have been offered smoking cessation advice in the last 15 months.

### **CHD Indicator 5**

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

### **CHD 5.1 Rationale**

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

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

### **CHD 5.2 Reporting and Verification**

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

### **CHD Indicator 6**

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

### **CHD 6.1 Rationale**

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

A major overview of randomised trials showed that a reduction of 5-6 mm Hg in blood pressure sustained over 5 years reduces coronary events by 20-25% in patients with coronary heart disease (Collins et al. Lancet 1990; 335: 827-38.)

### **CHD 6.2 Reporting and Verification**

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

### **CHD Indicator 7**

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

### **CHD 7.1 Rationale**

A number of trials have demonstrated that cholesterol lowering with statins significantly reduces cardiovascular or all-cause mortality in patients with angina or in patients following myocardial infarction. *Grade C Recommendation SIGN Guideline 51*

Further Information: <http://www.sign.ac.uk/guidelines/fulltext/51/section2.html>

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

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

### **CHD 7.2 Reporting and Verification**

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

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

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

### **CHD Indicator 8**

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

### **CHD 8.1 Rationale**

A number of Randomised Controlled Trials of statin therapy in the secondary prevention of CHD have shown a reduction in relative risk of cardiac events irrespective of the starting level of cholesterol (see reference in 7.1). It is likely that National Guidelines relating to statin therapy in patients with CHD will change to recommend statin therapy for all patients with CHD irrespective of their starting level of total cholesterol.

However, currently the Joint British Recommendations on Prevention of Coronary Heart Disease in Clinical Practice and SIGN Guidelines 41 and 51 recommend that patients who have a cholesterol of greater than 5mmol/l should be offered lipid lowering therapy.

The guidance here is given in terms of total cholesterol, as this is used in national guidance and in trials. However, future guidance may relate to reduction of LDL cholesterol, which is the more important component.

### **CHD 8.2 Reporting and Verification**

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

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

1. Inspection of the output from a computer search that has been used to provide information on this indicator
2. Inspection of a sample of records of patients with CHD to look at the proportion with recorded serum cholesterol 5mmol/l or less

3. Inspection of a sample of records of patients for whom a record of serum cholesterol at 5mmol/l is claimed, to see if there is evidence of this in the medical records.

#### **CHD Indicator 9**

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

##### **CHD 9.1 Rationale**

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

*Grade A Recommendation SIGN Guidelines 41/51*

Further Information: <http://www.sign.ac.uk/guidelines/fulltext/51/index.html>

Further Information: <http://www.sign.ac.uk/guidelines/fulltext/41/index.html>

##### **CHD 9.2 Reporting and Verification**

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

#### **CHD Indicator 10**

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

##### **CHD 10.1 Rationale**

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

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

*Grade A Recommendation SIGN Guidelines 41/51*

Further Information: <http://www.sign.ac.uk/guidelines/fulltext/51/index.html>

Further Information: <http://www.sign.ac.uk/guidelines/fulltext/41/index.html>

##### **CHD 10.2 Reporting and Verification**

The percentage of patients on the CHD register who have been prescribed a beta blocker in the last 6 months.

#### **CHD Indicator 11**

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

### **CHD 11.1 Rationale**

A number of trials have shown reduced mortality following myocardial infarction with the use of ACE inhibitors. The Heart Outcome Prevention Evaluation (HOPE) showed that ACE inhibitors are also of benefit in reducing coronary events and progression of coronary arteriosclerosis in patients without left ventricular systolic dysfunction. There is evidence that angiotensin II antagonists have a similar effect. This indicator is prospective with inclusion of patients diagnosed with a myocardial infarction after 1 April 2003.

*Grade A Recommendation SIGN Guideline 41*  
*Grade A Recommendation NICE Guideline A*

Further Information: <http://www.sign.ac.uk/guidelines/fulltext/41/index.html>  
Further information: <http://www.escardio.org/scinfo/Guidelines/98prevention.pdf>

### **CHD 11.2 Reporting and Verification**

The percentage of patients who have had a myocardial infarction after 1 April 2003 who have been prescribed an ACE inhibitor or A2 antagonist in the last 6 months.

#### **CHD Indicator 12**

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

### **CHD 12.1 Rationale**

This is a current recommendation from the Department of Health and the Joint Committee on Vaccination and Immunisation. ([www.doh.gov.uk/greenbook/](http://www.doh.gov.uk/greenbook/))

### **CHD 12.2 Reporting and Verification**

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

## Sub-Section: Left Ventricular Dysfunction (LVD)

Indicator	Points	Payment Stages
<b>Records</b>		
LVD 1. The practice can produce a register of patients with CHD and left ventricular dysfunction	4	
<b>Diagnosis and initial management</b>		
LVD 2. The percentage of patients with a diagnosis of CHD and left ventricular dysfunction (diagnosed after 1 April 2003) which has been confirmed by an echocardiogram	6	25-90%
<b>Ongoing Management</b>		
LVD 3. The percentage of patients with a diagnosis of CHD and left ventricular dysfunction who are currently treated with ACE inhibitors (or A2 antagonists)	10	25-70%

### LVD - Rationale for Inclusion of Indicator Set

The commonest cause of heart failure is myocardial dysfunction, which is most usually systolic with reduced left ventricular contraction and emptying. This set of indicators relates to this disease process – left ventricular systolic dysfunction (LVSD) - and should be applied to patients with LVSD due to ischaemic heart disease.

Indicators for patients with normal systolic function are outwith the scope of this indicator set.

#### LVD Indicator 1

**The practice can produce a register of patients with CHD and left ventricular dysfunction**

#### LVD 1.1 Rationale

A register is a prerequisite for monitoring patients with LVD. For patients diagnosed prior to April 2003 it is accepted that various diagnostic criteria may have been used. For this reason the presence of the diagnosis of heart failure in the records will be acceptable. However, practices may wish to review patients previously diagnosed and if appropriate attempt to confirm the diagnosis by echocardiography.

#### LVD 1.2 Reporting and Verification

The practice reports the number of patients with CHD and LVD and the number of patients with CHD and LVD as a proportion of total list size.

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

#### LVD Indicator 2

**The percentage of patients with a diagnosis of CHD and left ventricular dysfunction (diagnosed after 1 April 2003) which has been confirmed by an echocardiogram**

#### LVD 2.1 Rationale

Adequate pre-treatment investigation, examination and history-taking are important in all patients with suspected heart failure. The purpose of this assessment is to confirm or exclude a diagnosis of heart failure, to identify the cause of heart failure, ascertain aggravating factors and to act as a guide for future management and treatment.

Echocardiography is established as the single most important investigation in patients with heart failure. However, in primary care there may be pragmatic reasons why such an examination is not possible eg in frail immobile patients. A resting ECG is a useful screening tool. Significant LVD is unlikely in the presence of a completely normal ECG. The purpose of this indicator is to ensure that patients are correctly diagnosed as having heart failure, distinguishing them, for example, from patients with dependent oedema.  
*Grade C recommendation SIGN 35*

Further Information: <http://www.sign.ac.uk/guidelines/fulltext/36/index.html>

It is recognised that echocardiography resources may be limited in parts of the country. For this reason the criterion is prospective and will apply to patients receiving a diagnosis from 1 April 2003 onwards. In addition, exception-reporting will be available in cases where it is logistically impossible for a patient to have an echocardiogram. However, in such areas, the PCO would be expected to commission adequate echocardiography facilities as a priority.

Normal concentrations of N-terminal pro-brain natriuretic peptide (NT-proBNP) can be used to rule out LVD in patients with suspected heart failure. These patients would not be added to the LVD register or require further investigation. High concentrations of NT-proBNP may identify patients who require further investigation to confirm the diagnosis.

## **LVD 2.2 Reporting and Verification**

The practice should report those patients who have had an echocardiogram within 12 months of being added to the register in whom a new diagnosis of left ventricular dysfunction has been made since 1 April 2003.

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

1. Inspection of the output from a computer search that has been used to provide information on this indicator
2. Inspection of a sample of records of patients with CHD/LVD diagnosed after 1 April 2003 to look at the proportion with an echocardiogram result or referral
3. Inspection of a sample of records of patients for whom a record of echocardiogram is claimed, to see if there is evidence of this in the medical records.

### **LVD Indicator 3**

**The percentage of patients with a diagnosis of CHD and left ventricular dysfunction who are currently treated with ACE inhibitors (or A2 antagonists)**

## **LVD 3.1 Rationale**

In the absence of specific contraindications, all patients with left ventricular systolic dysfunction should be considered for treatment with an ACE inhibitor. ACE inhibitors have been shown to improve survival in patients with all grades of heart failure.

*Grade A Recommendation SIGN 35*

Further Information: <http://www.sign.ac.uk/guidelines/fulltext/35/index.html>

Evidence from trials suggests that the greatest benefits are achieved by treatment with maximum doses of ACE inhibitors (rather than choosing the dose that produces adequate symptomatic relief), and that moderate doses are less effective than high doses. ACE inhibitors should therefore be titrated up to the maximum BNF recommended doses wherever possible (which in some cases are lower than the doses used in trials). It is important to check renal function prior to commencing these drugs and after two weeks of treatment.

Where an ACE inhibitor produces unacceptable side-effects an angiotensin II receptor antagonist should be considered.

*Grade A Recommendation SIGN 35*

Further information: <http://www.sign.ac.uk/guidelines/fulltext/35/index.html>

A number of other therapeutic management options are recommended in the SIGN Guideline, for example the use of beta blockers.

Patients already treated with diuretics and/or digoxin and an ACE inhibitor, who are clinically stable and in NYHA classes I-III, should be considered for treatment with a beta blocker. Such patients should be under careful specialist supervision.

*Grade A Recommendation SIGN 35*

However, due to the complexity of their use and therefore the difficulty of including them as an indicator, they have not been included in the indicator set.

### **LVD 3.2 Reporting and Verification**

Practices should report the percentage of patients on the LVD register who have been prescribed an ACE inhibitor or A2 Inhibitor in the last 6 months.

## Stroke and Transient Ischaemic Attacks (TIA)

Indicator	Points	Payment Stages
<b>Records</b>		
STROKE 1. The practice can produce a register of patients with Stroke or TIA	4	
STROKE 2. The percentage of new patients with presumptive stroke (presenting after 1 April 2003) who have been referred for confirmation of the diagnosis by CT or MRI scan	2	25-80%
<b>Ongoing Management</b>		
STROKE 3. The percentage of patients with TIA or stroke who have a record of smoking status in the last 15 months, except those who have never smoked where smoking status need be recorded only once since diagnosis	3	25-90%
STROKE 4. The percentage of patients with a history of TIA or stroke who smoke and whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered in the last 15 months	2	25-70%
STROKE 5. The percentage of patients with TIA or stroke who have a record of blood pressure in the notes in the preceding 15 months	2	25-90%
STROKE 6. The percentage of patients with a history of TIA or stroke in whom the last blood pressure reading (measured in last 15 months) is 150/90 or less	5	25-70%
STROKE 7. The percentage of patients with TIA or stroke who have a record of total cholesterol in the last 15 months	2	25-90%
STROKE 8. The percentage of patients with TIA or stroke whose last measured total cholesterol (measured in last 15 months) is 5 mmol/l or less	5	25-60%
STROKE 9. The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken (unless a contraindication or side-effects are recorded)	4	25-90%
STROKE 10. The percentage of patients with TIA or stroke who have had influenza immunisation in the preceding 1 September to 31 March	2	25-85%

### Stroke/TIA - Rationale for Inclusion of Indicator Set

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

#### Stroke Indicator 1

**The practice can produce a register of patients with Stroke or TIA**

#### Stroke 1.1 Rationale

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

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

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

## Stroke 1.2 Reporting and Verification

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

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

### Stroke Indicator 2

**The percentage of new patients with presumptive stroke (presenting after 1 April 2003) who have been referred for confirmation of the diagnosis by CT or MRI scan**

## Stroke 2.1 Rationale

Randomised trials of the use of CT brain scanning have not been performed, but a clinical consensus exists that assessment of most patients with acute cerebrovascular events should include CT or MRI brain scanning because:

- Specific treatment of intracranial haemorrhage (eg neurosurgery, cessation/reversal of antithrombotic therapies) may be indicated if rapidly diagnosed
- There is conclusive evidence for the efficacy of antiplatelet therapy and anticoagulant agents in the secondary prevention of ischaemic stroke, but these drugs should be avoided in cases of haemorrhagic stroke
- Clinical scoring systems have been found to be unreliable in distinguishing ischaemic and haemorrhagic stroke.

*Grade C Recommendation SIGN 13*

Further information: <http://www.sign.ac.uk/pdf/sign13.pdf>

SIGN guideline 13 emphasises the importance of timing CT scanning, preferably within 48 hours and no later than seven days after an acute stroke. The diagnosis of stroke will often be made in secondary care and has to take account of locally based services.

TIA's (ie focal neurological symptoms which resolve within 24 hours) are almost invariably ischaemic in nature. Although CT or MRI scan can be helpful in managing TIA it is not considered essential that TIA patients receive a CT or MRI scan.

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

## Stroke 2.2 Reporting and Verification

The practice should report those patients who have been referred for a CT scan or MRI scan within 12 months of being added to the register in whom a new diagnosis of stroke has been made since 1 April 2003. The practice should also report those who have been referred up to three months before being added to the register.

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

1. Inspection of the output from a computer search that has been used to provide information on this indicator
2. Inspection of a sample of records of patients with stroke diagnosed after 1 April 2003 to look at the proportion with CT or MRI scan

3. Inspection of a sample of records of patients for whom a record of CT or MRI scan is claimed, to see if there is evidence of this in the medical records.

### **Stroke Indicator 3**

**The percentage of patients with TIA or stroke who have a record of smoking status in the last 15 months, except those who have never smoked where smoking status need be recorded only once since diagnosis**

#### **Stroke 3.1 Rationale**

There are few randomised clinical trials of the effects of risk factor modification in the secondary prevention of ischaemic or haemorrhagic stroke. Inferences can be drawn from the findings of primary prevention trials that cessation of cigarette smoking should be advocated.

*Grade C Recommendation SIGN 13*

Further information: <http://www.sign.ac.uk/pdf/sign13.pdf>

#### **Stroke 3.2 Reporting and Verification**

The aim of this indicator is to ensure that the smoking status of all patients is known in the previous year, making the assumption that patients who have never smoked will continue not to smoke (in order to avoid keeping asking them).

The numerator of the indicator is the number of stroke/TIA patients who have never smoked plus the number who have been recorded as ex- or current smokers in the past 15 months. The denominator is the total number of stroke/TIA patients. Thus:

*% with smoking status recorded (among patients with stroke/TIA) =*

*[no of never smoked] + [no recorded as ex- or current smokers in past 15 months]*

*\_\_\_\_\_*  
*[number with stroke/TIA]*

### **Stroke Indicator 4**

**The percentage of patients with a history of TIA or stroke who smoke and whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered in the last 15 months**

#### **Stroke 4.1 Rationale**

Smoking cessation evidence has mostly been investigated in the domain of ischaemic heart disease (IHD). Many strategies have been used to help people to stop smoking. A meta-analysis of controlled trials in patients post myocardial infarction showed that a combination of individual and group smoking cessation advice, and assistance reinforced on multiple occasions - initially during cardiac rehabilitation and reinforced by primary care teams - gave the highest success rates.

*Reference Grade B recommendation SIGN Guidelines 41/51*

Further Information: <http://www.sign.ac.uk/guidelines/fulltext/51/index.html>

Further Information: <http://www.sign.ac.uk/guidelines/fulltext/41/index.html>

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

Further Information: <http://www.nice.org.uk/pdf/NiceNRT39GUIDANCE.pdf>

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

#### **Stroke 4.2 Reporting and Verification**

The practice should report the percentage of patients on the stroke/TIA register who are current smokers who have been offered smoking cessation advice in the last 15 months.

##### **Stroke Indicator 5**

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

#### **Stroke 5.1 Rationale**

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

In one major overview, a long-term difference of 5-6 mm Hg in usual DBP is associated with about 35-40% less stroke over five years. (Collins et al. Lancet 1990; 335: 827-38).

*Grade A Recommendation RCP Stroke Guideline 2002*

Further Information:

<http://www.rcplondon.ac.uk/pubs/books/stroke/index.htm>

#### **Stroke 5.2 Reporting and Verification**

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

##### **Stroke Indicator 6**

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

#### **Stroke 6.1 Rationale**

See STROKE 5.1.

#### **Stroke 6.2 Reporting and Verification**

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

##### **Stroke Indicator 7**

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

## Stroke 7.1 Rationale

There is evidence for benefit in reducing cholesterol in ischaemic stroke and TIA. The issue around potential harm in haemorrhagic stroke is more controversial (Oliver MF. Cholesterol and strokes. *BMJ* 2000; 320: 459-460).

GJ Hankey reviewed the evidence in terms of establishing the role of cholesterol-modifying therapy in stroke prevention. This paper states "Population-based observational cohort studies show a variable weak positive relationship between increasing plasma total cholesterol concentrations and an increasing risk of ischaemic stroke, which is partly offset by a weaker negative association between decreasing total cholesterol concentrations and an increasing risk of haemorrhagic stroke. However, randomised controlled trials show unequivocally that lowering plasma total cholesterol by approximately 1.2 mmol/l (and LDL-cholesterol by 1.0 mmol/l) is associated with a reduced relative risk of stroke and other serious vascular events by at least a quarter, and probably a third, without any increase in haemorrhagic stroke, in a wide range of men and women (including individuals with previous stroke). The proportional reduction in stroke risk is consistent, irrespective of the patient's age, baseline plasma cholesterol concentration, and absolute risk of stroke (although perhaps less in very low-risk individuals), but is increased with greater degrees of cholesterol lowering (15% or more), and thus with statin medications, which are more potent than non-statin interventions in lowering cholesterol levels. The absolute reduction in stroke risk achieved by statins is greatest among individuals at highest risk of stroke. Preliminary evidence suggests that lowering total cholesterol levels by diet may be an effective adjunctive therapy to statins, and raising plasma HDL-cholesterol concentrations among patients with coronary heart disease and low HDL-cholesterol levels ( 1 mmol/l) by means of gemfibrozil may also effectively prevent stroke. In summary statin drugs are effective and safe in preventing initial and recurrent stroke."

*Curr Opin Lipidol* 2002 Dec;13(6):645-51

Given the vast majority of strokes and TIAs are ischaemic in origin, it is proposed that this indicator is applied. In recognition that where there is a proven haemorrhagic stroke clinicians may wish to weigh up the risks for the patient, the payment levels have been set at a lower level. Patients with haemorrhagic stroke could be exception reported for this reason.

## Stroke 7.2 Reporting and Verification

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

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

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

### Stroke Indicator 8

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

## Stroke 8.1 Rationale

See Stroke 7.1.

## Stroke 8.2 Reporting and Verification

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

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

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

### Stroke Indicator 9

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

## Stroke 9.1 Rationale

Long-term antiplatelet therapy reduces the risk of serious vascular events following a stroke by about a quarter. Antiplatelet therapy, normally aspirin, should be prescribed for the secondary prevention of recurrent stroke and other vascular events in patients who have sustained an ischaemic cerebrovascular event.

*Grade A recommendation SIGN 13*

Further information: <http://www.sign.ac.uk/pdf/sign13.pdf>

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

*Grade A Recommendation RCP Stroke Guideline*

Further Information:

[Http://www.rcplondon.ac.uk/pubs/books/stroke/ceeu\\_stroke\\_clinical11.htm#113](Http://www.rcplondon.ac.uk/pubs/books/stroke/ceeu_stroke_clinical11.htm#113)

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

*Grade A recommendation SIGN 13*

## Stroke 9.2 Reporting and Verification

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

**Stroke Indicator 10**

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

**Stroke 10.1 Rationale**

This is a current recommendation from the Departments of Health and the Joint Committee on Vaccination and Immunisation ([www.doh.gov.uk/greenbook/](http://www.doh.gov.uk/greenbook/)).

**Stroke 10.2 Reporting and Verification**

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

## Hypertension

Indicator	Points	Payment Stages
<b>Records</b>		
BP 1. The practice can produce a register of patients with established hypertension	9	
<b>Diagnosis and initial management</b>		
BP 2. The percentage of patients with hypertension whose notes record smoking status at least once since diagnosis	10	25-90%
BP 3. The percentage of patients with hypertension who smoke, whose notes contain a record that smoking cessation advice or referral to a specialist service, if available, has been offered at least once	10	25-90%
<b>Ongoing Management</b>		
BP 4. The percentage of patients with hypertension in whom there is a record of the blood pressure in the past 9 months	20	25-90%
BP 5. The percentage of patients with hypertension in whom the last blood pressure (measured in the last 9 months) is 150/90 or less	56	25-70%

### Hypertension - Rationale for Inclusion of Indicator Set

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

#### Hypertension (BP) Indicator 1

**The practice can produce a register of patients with established hypertension**

#### BP 1.1 Rationale

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

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

Drug treatment is also indicated in patients with sustained systolic blood pressures of 140-159mmHg or diastolic pressures of 90-99mmHg if target organ damage is present or there is evidence of established cardiovascular disease or diabetes or the 10 year risk of CHD is raised.

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

*British Hypertension Society Guidelines 1999*

Further information: <http://bmj.bmjournals.com/cgi/content/full/319/7210/630>  
<http://www.hyp.ac.uk/bhs/resources/guidelines.htm>

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

## BP 1.2 Reporting and Verification

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

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

### Hypertension (BP) Indicator 2

**The percentage of patients with hypertension whose notes record smoking status at least once since diagnosis**

## BP 2.1 Rationale

The only indicator relating to overall assessment included in the Quality and Outcomes Framework relates to smoking cessation. This is partly because of its importance, and partly because of the difficulties of consistently recording other aspects of the assessment of patients with hypertension.

In addition to smoking history, the British Hypertension Society recommends that all patients with hypertension should have a thorough history and physical examination. The aims are to elicit and document:

- Causes of hypertension, eg renal disease, endocrine disease
- Contributory factors eg obesity, excess alcohol intake
- Complications of hypertension eg previous stroke, left ventricular hypertrophy
- Cardiovascular risk eg smoking, family history.

Routine investigations should be limited to:

- Urine strip test for blood and protein
- Serum creatinine and electrolytes
- Blood glucose
- Serum total cholesterol
- ECG.

*British Hypertension Society Guidelines 1999*

Further information: <http://bmj.bmjournals.com/cgi/content/full/319/7210/630>  
<http://www.hyp.ac.uk/bhs/resources/guidelines.htm>

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

Risk calculators are available at: <http://www.hyp.ac.uk/bhs/resources/guidelines.htm>

The British Hypertension Society Guideline cites evidence that current management of patients with hypertension leaves patients at an unacceptably high risk of cardiovascular complications and death, particularly from CHD but also from stroke. In part this is a consequence of suboptimal blood pressure control but other factors have been shown to be important. These are:

- Evidence of target organ damage before treatment
- A history of cigarette smoking before treatment
- The serum cholesterol values before and during treatment.

It is anticipated that clinicians will address risk factors in all patients with hypertension. The contract requires practices to report on the important factor of cigarette smoking.

## BP 2.2 Reporting and Verification

Practices should report the percentage of patients on the hypertension disease register who have had their smoking status recorded at least once since diagnosis.

### **Hypertension (BP) Indicator 3**

**The percentage of patients with hypertension who smoke, whose notes contain a record that smoking cessation advice or referral to a specialist clinic, where available, has been offered at least once**

#### **BP 3.1 Rationale**

Evidence for smoking cessation is largely extrapolated from studies of patients with CHD.

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

*Reference Grade B recommendation SIGN Guidelines 41/51*

Further Information: <http://www.sign.ac.uk/guidelines/fulltext/51/index.html>

Further Information: <http://www.sign.ac.uk/guidelines/fulltext/41/index.html>

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

Further Information: <http://www.nice.org.uk/pdf/NiceNRT39GUIDANCE.pdf>

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

#### **BP 3.2 Reporting and Verification**

The practice should report the percentage of patients on the hypertension disease register who smoke who have been offered smoking cessation advice at least once.

### **Hypertension (BP) Indicator 4**

**The percentage of patients with hypertension in whom there is a record of the blood pressure in the past 9 months**

#### **BP 4.1 Rationale**

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

*British Hypertension Society Guidelines 1999*

Further information: <http://www.wellclosesquare.co.uk/protocol/bhsgui/bhsgui.htm>

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

#### **BP 4.2 Reporting and Verification**

Practices should report the percentage of patients on their hypertension register who have had a blood pressure measured in the last 9 months.

**Hypertension (BP) Indicator 5**

**The percentage of patients with hypertension in whom the last blood pressure (measured in the last 9 months) is 150/90 or less**

**BP 5.1 Rationale**

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

**BP 5.2 Reporting and Verification**

Practices should report the percentage of patients on their hypertension register whose last recorded blood pressure is 150/90 or less. The blood pressure must have been recorded in the last 9 months.

## Diabetes Mellitus (Diabetes)

This set of indicators refers to patients with both type 1 and type 2 diabetes.

Indicator	Points	Payment Stages
<b>Records</b>		
DM 1.The practice can produce a register of all patients with diabetes mellitus	6	
<b>Ongoing Management</b>		
DM 2.The percentage of patients with diabetes whose notes record BMI in the previous 15 months	3	25-90%
DM 3. The percentage of patients with diabetes in whom there is a record of smoking status in the previous 15 months, except those who have never smoked where smoking status need be recorded only once since diagnosis	3	25-90%
DM 4. The percentage of patients with diabetes who smoke and whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered in the last 15 months	5	25-90%
DM 5. The percentage of diabetic patients who have a record of HbA1c or equivalent in the previous 15 months	3	25-90%
DM 6. The percentage of patients with diabetes in whom the last HbA1C is 7.4 or less (or equivalent test/reference range depending on local laboratory) in last 15 months	16	25-50%
DM 7. The percentage of patients with diabetes in whom the last HbA1C is 10 or less (or equivalent test/reference range depending on local laboratory) in last 15 months	11	25-85%
DM 8. The percentage of patients with diabetes who have a record of retinal screening in the previous 15 months	5	25-90%
DM 9.The percentage of patients with diabetes with a record of the presence or absence of peripheral pulses in the previous 15 months	3	25-90%
DM 10. The percentage of patients with diabetes with a record of neuropathy testing in the previous 15 months	3	25-90%
DM 11. The percentage of patients with diabetes who have a record of the blood pressure in the past 15 months	3	25-90%
DM 12. The percentage of patients with diabetes in whom the last blood pressure is 145/85 or less	17	25-55%
DM 13. The percentage of patients with diabetes who have a record of micro-albuminuria testing in the previous 15 months (exception reporting for patients with proteinuria)	3	25-90%
DM 14. The percentage of patients with diabetes who have a record of serum creatinine testing in the previous 15 months	3	25-90%
DM 15. The percentage of patients with diabetes with a diagnosis of proteinuria or micro-albuminuria who are treated with ACE inhibitors (or A2 antagonists)	3	25-70%
DM 16. The percentage of patients with diabetes who have a record of total cholesterol in the previous 15 months	3	25-90%
DM 17. The percentage of patients with diabetes whose last measured total cholesterol within previous 15 months is 5 or less	6	25-60%
DM 18. The percentage of patients with diabetes who have had influenza immunisation in the preceding 1 September to 31 March	3	25-85%

### Diabetes - Rationale for Inclusion of Indicator Set

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

The indicators for diabetes are based on widely recognised approaches to the care of diabetes. Detailed guidelines for health professionals are published by Diabetes UK (see [www.diabetes.org.uk/catalogue/reports.htm](http://www.diabetes.org.uk/catalogue/reports.htm)), and by SIGN - the Scottish Intercollegiate Guidelines Network (see [www.sign.ac.uk/guidelines/published/index.html#Diabetes](http://www.sign.ac.uk/guidelines/published/index.html#Diabetes)). The SIGN website contains detailed evidence tables, and links to published articles. The English National Service Framework for Diabetes is available at <http://www.doh.gov.uk/nsf/diabetes/> - this site also includes details of the evidence behind a range of recommendations. NICE has also published guidance on a number of aspects of diabetic control ([www.nice.nhs.uk](http://www.nice.nhs.uk)).

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

Rather than including a substantial number of individual indicators, there has been discussion about whether a composite indicator such as "the percentage of diabetic patients who have had an annual check" would suffice. The view taken was that this would not make data collection any easier for GPs, since they would still have to satisfy their PCO at periodic visits that annual checks had included those items recommended in national guidance.

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

#### Diabetes (DM) Indicator 1

The practice can produce a register of all patients with diabetes mellitus

##### DM 1.1 Rationale

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

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

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

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

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

##### DM 1.2 Reporting and Verification

Practices should report the number of patients on their diabetic register (age 17 and over) and the number of patients on their diabetic register (age 17 and over) as a proportion of their total list size.

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

#### **Diabetes (DM) Indicator 2**

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

##### **DM 2.1 Rationale**

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

##### **DM 2.2 Reporting and Verification**

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

#### **Diabetes (DM) Indicator 3**

**The percentage of patients with diabetes in whom there is a record of smoking status in the previous 15 months, except those who have never smoked where smoking status need be recorded only once since diagnosis**

##### **DM 3.1 Rationale**

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

##### **DM 3.2 Reporting and Verification**

The aim of this indicator is to ensure that the smoking status of all patients is known in the previous year, making the assumption that patients who have never smoked will continue not to smoke (in order to avoid keeping asking them).

The numerator of the indicator is the number of patients with diabetes who have never smoked plus the number who have been recorded as ex- or current smokers in the past 15 months. The denominator is the total number of patients with diabetes. Thus:

*% with smoking status recorded (among patients with diabetes) =*

*[no of never smoked] + [no recorded as ex- or current smokers in past 15 months]*

*\_\_\_\_\_*  
*[number with diabetes]*

#### **Diabetes (DM) Indicator 4**

**The percentage of patients with diabetes who smoke and whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered in the last 15 months**

##### **DM 4.1 Rationale**

Because vascular risks are so high, regular reminders to patients about smoking are justified. Simple advice to stop smoking given by a doctor, a nurse or a counsellor has a small but significant effect on helping smokers to quit. Health professionals involved in caring for patients with diabetes should advise them not to smoke.

*Grade A Recommendation SIGN 55*

Further Information: <http://www.sign.ac.uk/guidelines/fulltext/55/index.html>

Smoking cessation services will also help diabetic smokers to quit. A number of studies have recently shown benefits from the prescription of nicotine replacement therapy or bupropion in patients who have indicated a wish to quit smoking. Further guidance is available from NICE.

Further Information: <http://www.nice.org.uk/pdf/NiceNRT39GUIDANCE.pdf>

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

#### **DM 4.2 Reporting and Verification**

The practice should report the percentage of patients on the diabetic register who are current smokers who have been offered smoking cessation advice in the last 15 months.

#### **Diabetes Indicator (DM) 5**

**The percentage of diabetic patients who have a record of HbA1c or equivalent in the previous 15 months**

#### **DM 5.1 Rationale**

HbA1c is a marker of long-term control of diabetes. Better control leads to fewer complications in both insulin dependent and non-insulin dependent patients with diabetes. There is no trial evidence to support the frequency of HbA1c measurement.

Fructosamine may be used in some areas as an alternative to HbA1c or, for example, in some patients with haemoglobinopathies.

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

*Grade D Recommendation NICE Inherited Guideline G*

For the purposes of contract monitoring the indicator has been set at a minimal level assuming an HbA1c measurement at least annually.

#### **DM 5.2 Reporting and Verification**

The practice should report the percentage of diabetic patients who have had an HbA1c or equivalent in the previous 15 months.

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

1. Inspection of the output from a computer search that has been used to provide information on this indicator
2. Inspection of a sample of records of patients with diabetes to look at the proportion with recorded HbA1c in last 15 months

3. Inspection of a sample of records of patients for whom a record of HbA1c is claimed, to see if there is evidence of this in the medical records.

#### **Diabetes (DM) Indicator 6**

**The percentage of patients with diabetes in whom the last HbA1C is 7.4 or less (or equivalent test/reference range depending on local laboratory) in last 15 months**

##### **DM 6.1 Rationale**

For each individual a target HbA1c should be set between 6.5% and 7.5% based on the risk of macrovascular and microvascular complications.

*Grade B Recommendation NICE Inherited Guideline G*

For the purposes of the contract 7.4 (or equivalent) has been selected as an optimal level of control for the purposes of audit and reporting. Where fructosamine is used, for example in patients with haemoglobinopathies, local standards may need to be developed for this indicator.

It is recognised that there may be variations in test availability and in normal ranges in different parts of the UK. If this is the case, the PCO may stipulate a different but equivalent range for this indicator. This issue is discussed in the English NSF under Standards: Supplementary information: Clinical care of adults with diabetes: Monitoring blood glucose control.

<http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Diabetes/fs/en>

##### **DM 6.2 Reporting and Verification**

The practice should report the percentage of patients on the diabetic register in which the last HbA1c measurement was 7.4 or less. The test must have been carried out in the last 15 months.

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

1. Inspection of the output from a computer search that has been used to provide information on this indicator
2. Inspection of a sample of record of patients with diabetes to look at the proportion with last recorded HbA1c 7.4 or less
3. Inspection of a sample of records of patients for whom a record of HbA1c 7.4 or less is claimed, to see if there is evidence of this in the medical records.

#### **Diabetes (DM) Indicator 7**

**The percentage of patients with diabetes in whom the last HbA1C is 10 or less (or equivalent test/reference range depending on local laboratory) in last 15 months**

##### **DM 7.1 Rationale**

Reaching optimal levels of control in diabetic patients is difficult. For this reason a second outcome indicator has been introduced to encourage working with patients with high HbA1c to bring the level to 10 or less. Where fructosamine is used, for example in patients with haemoglobinopathies, local standards may need to be developed for this indicator.

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

discussed in the English NSF (<http://www.doh.gov.uk/nsf/diabetes/>) under Standards: Supplementary information: Clinical care of adults with diabetes: Monitoring blood glucose control.

### **DM 7.2 Reporting and Verification**

The practice should report the percentage of patients on the diabetic register in which the last HbA1c measurement was ten or less. The test must have been carried out in the last 15 months.

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

1. Inspection of the output from a computer search that has been used to provide information on this indicator
2. Inspection of a sample of records of patients with diabetes to look at the proportion with last recorded HbA1c 10 or less
3. Inspection of a sample of records of patients for whom a record of HbA1c 10 or less is claimed, to see if there is evidence of this in the medical records.

#### **Diabetes (DM) Indicator 8**

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

### **DM 8.1 Rationale**

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

*Grade B Recommendation SIGN 55*

Further Information: <http://www.sign.ac.uk/guidelines/fulltext/55/index.html>

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

### **DM 8.2 Reporting and Verification**

Practices should report the percentage of patients on the diabetic register who have had retinal screening performed in the last 15 months.

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

#### **Diabetes (DM) Indicator 9**

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

### **DM 9.1 Rationale**

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

## **DM 9.2 Reporting and Verification**

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

### **Diabetes (DM) Indicator 10**

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

#### **DM 10.1 Rationale**

See DM 9.1

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

#### **DM 10.2 Reporting and Verification**

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

### **Diabetes (DM) Indicator 11**

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

#### **DM 11.1 Rationale**

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

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

*Grade D Recommendation NICE Inherited Guideline H*

Further Information: <http://www.nice.org.uk/cat.asp?c=38551>

#### **DM 11.2 Reporting and Verification**

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

### **Diabetes (DM) Indicator 12**

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

#### **DM 12.1 Rationale**

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

*Grade A Recommendation SIGN 55*

Target diastolic in patients with diabetes is less than or equal to 80 mmHg.

*Grade A Recommendation SIGN 55*

*Recommendation British Hypertension Society Guideline 1999*

Target systolic in patients with diabetes is less than or equal to 140 mmHg.

*Grade D Recommendation SIGN 55*

*Recommendation British Hypertension Society Guideline 1999*

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

Further Information: <http://www.sign.ac.uk/guidelines/fulltext/55/index.html>

Further information: <http://www.wellclosesquare.co.uk/protocol/bhsgui/bhsgui.htm>

## **DM 12.2 Reporting and Verification**

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

### **Diabetes (DM) Indicator 13**

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

## **DM 13.1 Rationale**

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

*Grade D Recommendation SIGN 55*

*Grade C Recommendation NICE Inherited Guideline F*

Further Information: <http://www.sign.ac.uk/guidelines/fulltext/55/index.html>

Further Information: <http://www.nice.org.uk/article.asp?a=27964>

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

## **DM 13.2 Reporting and Verification**

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

**Diabetes (DM) Indicator 14**

**The percentage of patients with diabetes who have a record of serum creatinine testing in the previous 15 months**

**DM 14.1 Rationale**

See DM 13.1

**DM 14.2 Reporting and Verification**

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

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

1. Inspection of the output from a computer search that has been used to provide information on this indicator
2. Inspection of a sample of records of patients with diabetes to look at the proportion with recorded serum creatinine
3. Inspection of a sample of records of patients for whom a record of serum creatinine is claimed, to see if there is evidence of this in the medical records.

**Diabetes (DM) Indicator 15**

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

**DM 15.1 Rationale**

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

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

*Grade A Recommendation SIGN 55*

Further Information: <http://www.sign.ac.uk/guidelines/fulltext/55/index.html>

**DM 15.2 Reporting and Verification**

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

**Diabetes (DM) Indicator 16**

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

**DM 16.1 Rationale**

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

*Grade C Recommendation SIGN Guideline 51*

Further Information: <http://www.sign.ac.uk/guidelines/fulltext/51/section2.html>

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

**DM 16.2 Reporting and Verification**

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

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

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

**Diabetes (DM) Indicator 17**

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

**DM 17.1 Rationale**

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

The age when a statin should be initiated is unclear. It is pragmatically suggested that all diabetic patients over the age of 40 with a cholesterol of greater than 5mmol/l should be treated with a statin. Below the age of 40 a decision needs to be reached between the doctor and the patient and may involve assessment of other risk factors and the actual age of the patient. Where a statin is not prescribed the patient can be exception reported.

Further Information:

Heart Protection Study Collaborative Group: MRC/BHF Heart Protection Study of cholesterol-lowering with simvastatin in 5,963 people with diabetes: a randomised placebo-controlled trial. *Lancet* 361:2005-2016, 2003

Mortality from Coronary Heart Disease in Subjects with Type 2 Diabetes and in Nondiabetic Subjects with and without Prior Myocardial Infarction

Steven M. Haffner, M.D., Seppo Lehto, M.D., Tapani Rönnemaa, M.D., Kalevi Pyörälä, M.D., and Markku Laakso, M.D. *New England Journal of Medicine* 339:229-234

### **DM 17.2 Reporting and Verification**

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

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

1. Inspection of the output from a computer search that has been used to provide information on this indicator
2. Inspection of a sample of records of patients with diabetes to look at the proportion with recorded serum cholesterol less than 5 mmol/l
3. Inspection of a sample of records of patients for whom a record of serum cholesterol is less than 5 mmol/l is claimed, to see if there is evidence of this in the medical records.

### **Diabetes (DM) Indicator 18**

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

### **DM 18.1 Rationale**

This is a current recommendation from the Departments of Health and the Joint Committee on Vaccination and Immunisation ([www.doh.gov.uk/greenbook/](http://www.doh.gov.uk/greenbook/)).

### **DM 18.2 Reporting and Verification**

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

## Chronic Obstructive Pulmonary Disease (COPD)

Indicator	Points	Payment Stages
<b>Records</b>		
COPD 1. The practice can produce a register of patients with COPD	5	
<b>Initial diagnosis</b>		
COPD 2. The percentage of patients in whom diagnosis has been confirmed by spirometry including reversibility testing for newly diagnosed patients with effect from 1 April 2003	5	25-90%
COPD 3. The percentage of all patients with COPD in whom diagnosis has been confirmed by spirometry including reversibility testing	5	25-90%
<b>Ongoing management</b>		
COPD 4. The percentage of patients with COPD in whom there is a record of smoking status in the previous 15 months, except those who have never smoked where smoking status need be recorded only once since diagnosis	6	25-90%
COPD 5. The percentage of patients with COPD who smoke, whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered in the past 15 months	6	25-90%
COPD 6. The percentage of patients with COPD with a record of FeV1 in the previous 27 months	6	25-70%
COPD 7. The percentage of patients with COPD receiving inhaled treatment in whom there is a record that inhaler technique has been checked in the preceding 2 years	6	25-90%
COPD 8. The percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March	6	25-85%

### COPD - Rationale for Inclusion of Indicator Set

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

The majority of patients with COPD are managed by general practitioners and members of the primary healthcare team with onward referral to secondary care when required. Consultation rates in patients with COPD are 2 to 4 times higher than the equivalent rates for patients with angina. This indicator set focuses on the diagnosis and management of patients with symptomatic COPD.

#### COPD Indicator 1

**The practice can produce a register of patients with COPD**

#### COPD 1.1 Rationale

A register is a prerequisite for monitoring patients with COPD.

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

It is not anticipated that patients will be registered as asthmatic and as having COPD. Patients diagnosed as COPD who were previously on the asthma register should be coded as inactive on the asthma register.

See COPD 3.1.

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

### **COPD 1.2 Reporting and verification**

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

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

#### **COPD Indicator 2**

**The percentage of patients in whom diagnosis has been confirmed by spirometry including reversibility testing for newly diagnosed patients with effect from 1 April 2003**

### **COPD 2.1 Rationale**

COPD is diagnosed if:

the patient has an FEV<sub>1</sub> of less than 70% of predicted normal  
and has an FEV<sub>1</sub>/FVC ratio of less than 70%  
and there is a less than 15% response to a reversibility test.

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

The FEV<sub>1</sub> is set at 70% although the GOLD and BTS guidelines state 80%. The rationale is that a significant number of patients with an FEV<sub>1</sub> less than 80% predicted may have minimal symptoms. The use of 70% enables clinicians to concentrate on symptomatic COPD.

Unlike asthma, airflow obstruction in COPD as measured by the FEV<sub>1</sub> can never be returned to normal values.

Further information:

BTS COPD Guidelines [http://www.brit-thoracic.org.uk/public\\_content.asp?pageid=7&catid=36&subcatid=134](http://www.brit-thoracic.org.uk/public_content.asp?pageid=7&catid=36&subcatid=134)  
GOLD Guidelines [www.goldcopd.com/](http://www.goldcopd.com/)

It is recognised that spirometry has not been standard practice or available in many general practices across the UK until recently. This indicator is therefore prospective, and only applies to new diagnoses of COPD. This will encourage more accurate diagnosis of COPD. For the purposes of the Quality and Outcomes Framework spirometry being undertaken between three months before and twelve months after a diagnosis of COPD being made would be considered as having met the requirements of this indicator.

There has been some discussion around the issue of spirometry testing and reversibility. While it is recognised that there may be an element of reversibility in patients with COPD the definition centres on the lack of reversibility. Patients with reversible airways obstruction should be included in the asthma disease register.

### **COPD 2.2 Reporting and Verification**

Practices should report the percentage of patients who were diagnosed after 1 April 2003 who have a record of diagnosis confirmed by spirometry including reversibility testing.

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

1. Inspection of the output from a computer search that has been used to provide information on this indicator
2. Inspection of a sample of records of patients with COPD diagnosed after 1 April 2003 to look at the proportion with a record of spirometry
3. Inspection of a sample of records of patients diagnosed after 1 April 2003 for whom a record of spirometry is claimed, to see if there is evidence of this in the medical records.

### **COPD Indicator 3**

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

#### **COPD 3.1 Rationale**

Some practices have been carrying out spirometry in COPD for some time. This indicator enables practices to be rewarded for work already done. Practices may also wish to review older patients with a view to making a more accurate diagnosis. The analysis is the same as for indicator COPD2 but involves all patients with a diagnosis of COPD.

#### **COPD 3.2 Reporting and Verification**

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

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

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

### **COPD Indicator 4**

**The percentage of patients with COPD in whom there is a record of smoking status in the previous 15 months, except those who have never smoked where smoking status need be recorded only once since diagnosis**

#### **COPD 4.1 Rationale**

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

*Grade A Evidence GOLD Guidelines*

Further Information: GOLD Guidelines [www.goldcopd.com/](http://www.goldcopd.com/)

There is no evidence relating to the frequency that smoking status should be recorded but it is important to promote cessation and continued abstinence. Smoking status should be reviewed annually, with the exception of those who have never smoked where smoking status need be recorded only once since diagnosis.

#### **COPD 4.2 Reporting and Verification**

The aim of this indicator is to ensure that the smoking status of all patients is known in the previous year, making the assumption that patients who have never smoked will continue not to smoke (in order to avoid keeping asking them).

The practice should report the percentage of patients on the COPD register in whom smoking status has been recorded in the last 15 months, plus those who have never smoked where smoking status has been recorded at least once since diagnosis.

#### **COPD Indicator 5**

**The percentage of patients with COPD who smoke, whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered in the past 15 months**

#### **COPD 5.1 Rationale**

Brief tobacco dependence treatment is effective and every tobacco user should be offered at least this treatment at every visit to the health care provider.

*Grade A Evidence GOLD Guideline*

Further Information:GOLD Guidelines [www.goldcopd.com/](http://www.goldcopd.com/)

The criterion does not specify the form of advice, which could range from simple advice to substitute prescribing to attendance at smoking cessation clinics.

#### **COPD 5.2 Reporting and Verification**

The practice should report the percentage of patients on the COPD register who are current smokers who have been offered smoking cessation advice in the last 15 months.

#### **COPD Indicator 6**

**The percentage of patients with COPD with a record of FEV<sub>1</sub> in the previous 27 months**

#### **COPD 6.1 Rationale**

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

There are no clear guidelines with regard to the optimum frequency of spirometry for patients with COPD. This has been pragmatically set in the quality framework at every two years. The purpose of regular monitoring is to identify patients with increasing severity of disease who may benefit from referral for more intensive treatments.

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

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

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

*Grade A Evidence GOLD Guidelines*

Further Information: GOLD Guidelines [www.goldcopd.com/](http://www.goldcopd.com/)

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

### **COPD 6.2 Reporting and Verification**

Practices should report the percentage of patients on the COPD register who have had spirometry performed in the last 27 months.

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

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

#### **COPD Indicator 7**

**The percentage of patients with COPD receiving inhaled treatment in whom there is a record that inhaler technique has been checked in the preceding 27 months**

### **COPD 7.1 Rationale**

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

*BTS COPD Guidelines*

Further information: [www.brit-thoracic.org.uk/guide/download\\_guide.html](http://www.brit-thoracic.org.uk/guide/download_guide.html)

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. There is no clear indication from the literature as to the required frequency of checking inhaler technique. A pragmatic view has been taken that this should be at least every two years.

### **COPD 7.2 Reporting and Verification**

The practice should report the percentage of patients on the COPD register in whom inhaler technique has been checked in the last 27 months. Patients not on therapy which involves the use of inhalers should be exception-reported.

**COPD Indicator 8**

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

**COPD 8.1 Rationale**

This is a current recommendation from the Departments of Health and the Joint Committee on Vaccination and Immunisation ([www.doh.gov.uk/greenbook/](http://www.doh.gov.uk/greenbook/)).

**COPD 8.2 Reporting and Verification**

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

## Epilepsy

Indicator	Points	Payment Stages
<b>Records</b>		
EPILEPSY 1. The practice can produce a register of patients receiving drug treatment for epilepsy	2	
<b>Ongoing Management</b>		
EPILEPSY 2. The percentage of patients age 16 and over on drug treatment for epilepsy who have a record of seizure frequency in the previous 15 months	4	25-90%
EPILEPSY 3. The percentage of patients age 16 and over on drug treatment for epilepsy who have a record of medication review in the previous 15 months	4	25-90%
EPILEPSY 4. The percentage of patients age 16 and over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the last 15 months	6	25-70%

### Epilepsy - Rationale for Inclusion of Indicator Set

Epilepsy is the most common serious neurological condition, affecting about 5 to 10 per 1000 of the population at any one time. Few epilepsies are preventable, but much of the handicap that results could be prevented by appropriate clinical management.

#### Epilepsy Indicator 1

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

#### Epilepsy 1.1 Rationale

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

It is proposed that the disease register includes patients aged 16 and over as care for younger patients is generally undertaken by specialists.

#### Epilepsy 1.2 Reporting and Verification

The practice reports the number of patients aged 16 and over on its epilepsy disease register and the number of patients aged 16 and over on its epilepsy disease register as a proportion of total list size.

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

#### Epilepsy Indicator 2

**The percentage of patients aged 16 and over on drug treatment for epilepsy who have a record of seizure frequency in the previous 15 months**

#### Epilepsy 2.1 Rationale

Epilepsy is often poorly managed in general practice, and there are insufficient specialist resources to provide specialist supervision for most patients.

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

- Seizure type and frequency, including date of last seizure
- Antiepileptic drug therapy and dosage
- Any adverse drug reactions arising from antiepileptic drug therapy
- Key indicators of the quality of care ie topics discussed and plans for future review

*Grade C Recommendation SIGN 21*

Further information: <http://www.sign.ac.uk/pdf/sign21.pdf>

No recommendation has been made by SIGN on the frequency of the review. A pragmatic decision has been made to set this as annual.

### **Epilepsy 2.2 Reporting and Verification**

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

#### **Epilepsy Indicator 3**

**The percentage of patients aged 16 and over on drug treatment for epilepsy who have a record of medication review in the previous 15 months**

### **Epilepsy 3.1 Rationale**

See Epilepsy 2.1

### **Epilepsy 3.2 Reporting and Verification**

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

**Epilepsy Indicator 4**

**The percentage of patients aged 16 and over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the last 15 months**

**Epilepsy 4.1 Rationale**

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

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

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

**Epilepsy 4.2 Reporting and Verification**

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

## Monitoring of Hypothyroidism

Indicator	Points	Payment stages
<b>Records</b>		
THYROID 1. The practice can produce a register of patients with hypothyroidism	2	
<b>Ongoing Management</b>		
THYROID 2. The percentage of patients with hypothyroidism with thyroid function tests recorded in the previous 15 months	6	25-90%

### Hypothyroidism - Rationale for Inclusion of Indicator Set

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

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

Monitoring of hypothyroidism is almost entirely undertaken in primary care.

#### Hypothyroid (THYROID) Indicator 1

**The practice can produce a register of patients with hypothyroidism**

#### Thyroid 1.1 Rationale

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

#### Thyroid 1.2 Reporting and Verification

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

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

#### Hypothyroid (THYROID) Indicator 2

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

#### Thyroid 2.1 Rationale

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

## **Thyroid 2.2 Reporting and Verification**

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

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

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

## Cancer

Indicator	Points	Payment stage
<b>Records</b>		
CANCER 1. The practice can produce a register of all cancer patients diagnosed after 1 April 2003	6	
<b>Ongoing Management</b>		
CANCER 2. The percentage of patients with cancer diagnosed from 1 April 2003 with a review by the practice recorded within six months of confirmed diagnosis. This should include an assessment of support needs, if any, and a review of co-ordination arrangements with secondary care	6	25-90%

### Cancer - Rationale for Inclusion of Indicator Set

Cancer is a clinical priority in all four countries.

It is recognised that the principal active management of cancers occurs in the secondary care setting.

General practitioners often have a key role in the referral and subsequently in providing a support role and in ensuring that care is appropriately co-ordinated.

This indicator set is not evidence-based.

#### Cancer Indicator 1

**The practice can produce a register of all cancer patients diagnosed after 1 April 2003**

##### Cancer 1.1 Rationale

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

##### Cancer 1.2 Reporting and Verification

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

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

#### Cancer Indicator 2

**The percentage of patients with cancer diagnosed from 1 April 2003 with a review by the practice recorded within six months of confirmed diagnosis. This should include an assessment of support needs, if any, and a review of co-ordination arrangements with secondary care**

##### Cancer 2.1 Rationale

Most general practitioners will see patients with a new cancer diagnosis following assessment and management in a secondary or tertiary care setting. The purpose of the review is usually to provide support

to the patient and to ensure that follow-up arrangements between the GP and the secondary care service are clear both to the patient and the GP.

### **Cancer 2.2 Reporting and Verification**

The practice reports the number of patients with cancer diagnosed since 1 April 2003 with a review recorded in the six months after diagnosis. QMAS will pick up and report the code 8BAV. 'cancer care review'.

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

## Mental Health (MH)

Additional indicators for mental health care are contained within the organisational indicators, relating to significant event audit (especially following suicide or compulsory admission) – see *Education and Training 7*, and follow-up of patients receiving depot injections in the practice – see *Medicines Management 7*.

Indicator	Points	Payment stages
<b>Records</b>		
MH 1. The practice can produce a register of people with severe long-term mental health problems who require and have agreed to regular follow-up	7	
<b>Ongoing management</b>		
MH 2. The percentage of patients with severe long-term mental health problems with a review recorded in the preceding 15 months. This review includes a check on the accuracy of prescribed medication, a review of physical health and a review of co-ordination arrangements with secondary care	23	25-90%
MH 3. The percentage of patients on lithium therapy with a record of lithium levels checked within the previous 6 months	3	25-90%
MH 4. The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 15 months	3	25-90%
MH 5. The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the previous 6 months	5	25-70%

## Mental Health - Rationale for Inclusion of Indicator Set

There are relatively few indicators of the quality of mental health care in relation to the importance of these conditions. The reason for this is that, for common mental health problems presenting to general practitioners, there are very few indicators that could be collected using information likely to be found in the medical records. There are few indicators suitable for incentivising the process of care similar to those used in other chronic diseases. This reflects the complexity of mental health problems, and reflects the complex mix of physical, psychological and social issues that present to general practitioners. The indicators included in the Quality and Outcomes Framework can therefore only be regarded as providing a very partial view on the quality of mental health care.

For many patients with mental health problems, the most important indicators relate to the inter-personal skills of the doctor, the time given in consultations and the opportunity to discuss a range of management options. Within the 'patient experience' section of the quality framework, there exists the opportunity to focus patient surveys on particular groups of patients. This would be one way in which a practice could look in more detail at the quality of care experienced by people with mental health problems.

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

### Mental Health (MH) Indicator 1

**The practice can produce a register of people with severe long-term mental health problems who require and have agreed to regular follow-up**

#### MH 1.1 Rationale

In order to carry out the reviews required below, it will be necessary to have a list of patients with severe long-term mental health problems. There are considerable difficulties around the diagnostic labelling of chronic mental illness. In the Quality and Outcomes Framework, unlike all the other clinical areas, we have

not specified specific diagnostic labels to be used. The principle adopted is the construction of a register based on patient need.

Practices would normally wish to consider including all patients with psychotic illness, patients treated under a care programme approach and patients requiring complex packages of care from a multi-disciplinary secondary care team. In England, this would include all patients being treated under the 'enhanced level' of the care programme approach. These are patients with multiple care needs, who often require inter-agency co-ordination, and may be at risk of disengaging themselves from services.

Other practices may also wish to include on a register patients with long-term depression, as there is evidence that the sort of structured care applied to other chronic diseases may also benefit patients with depression. (Wagner EH, Simon GE. Managing depression in primary care: the type of treatment matters less than ensuring it is done properly and followed up. *BMJ* 2001;322:746-747).

Practices must use their discretion, and should retain flexibility as to who is included on the register. For example, a patient who has had two episodes of mania in the past six years but who on each occasion has returned to work in a position of high public visibility may not be an appropriate individual to place on the register and may object to inclusion. Practices can however, be expected to describe which patients they include, and how, in general, those patients are identified for inclusion on the register.

There is more guidance on setting up a register on pages 29 and 30 of: Gask et al. *A practical guide to the National Service Framework for Mental Health*. This is published by the National Primary Care Research and Development Centre and can be downloaded from [www.npcrdc.man.ac.uk](http://www.npcrdc.man.ac.uk)

## **MH 1.2 Reporting and Verification**

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

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

### **Mental Health (MH) Indicator 2**

**The percentage of patients with severe long-term mental health problems with a review recorded in the preceding 15 months. This review includes a check on the accuracy of prescribed medication, a review of physical health and a review of co-ordination arrangements with secondary care**

## **MH 2.1 Rationale**

In many cases, the bulk of care for psychiatric care patients with long-term mental health problems will be provided by specialist services, so it is not appropriate to assess the general practitioner on the basis of care which may be largely outwith his or her control. Nevertheless, there are some aspects of management which often lie within the general practitioner's responsibility. One is physical health. Patients with severe mental health problems are at considerably increased risk of physical ill-health. Physical problems are often neglected or managed poorly. It is therefore good practice for a member of the practice team to review each patient's physical health on an annual basis.

A review of physical health will normally include:

- regular preventive care, eg cervical cytology
- issues relating to alcohol or drug use
- smoking and heart disease (including history suggestive of arrhythmias – Hennessy et al. *BMJ* 2002;325:1070)
- risk of diabetes from olanzepine and risperidone (Koro et al. *BMJ* 2002; 325: 243).

At the same time, the accuracy of medication which the general practitioner is prescribing can be checked. In particular, where the GP is prescribing for the patient, it is important to review medications on a regular basis, as with all repeat medications where the patient may not be in regular contact with the GP.

In addition, an annual check is an opportunity to review co-ordination arrangements with secondary care, eg for details of CPN and other services to be recorded in the notes, and to summarise what services are

actually being received. This information can be invaluable if the patient presents to the GP with a deterioration in his or her condition.

There is more guidance on regular reviews of patients with mental health problems on pages 30 and 31 of: Gask et al. *A practical guide to the National Service Framework for Mental Health*. This is published by the National Primary Care Research and Development Centre and can be downloaded from [www.npcrdc.man.ac.uk](http://www.npcrdc.man.ac.uk).

### **MH 2.3 Reporting and Verification**

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

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

#### **Mental Health (MH) Indicator 3**

**The percentage of patients on lithium therapy with a record of lithium levels checked within the previous 6 months**

#### **MH 3.1 Rationale**

Lithium monitoring is essential due to the narrow therapeutic range of serum lithium and the potential toxicity from intercurrent illness, declining renal function or co-prescription of drugs eg thiazide diuretics or NSAIDs which may reduce lithium excretion.

[www.jr2.ox.ac.uk/bandolier/band74/b74-6.html](http://www.jr2.ox.ac.uk/bandolier/band74/b74-6.html).

It is therefore necessary to check calcium and thyroid function on a regular basis as well as renal function.

There is no definitive evidence on the frequency of lithium level checks but most practitioners would monitor lithium levels when stable every 3 to 6 months. Where a practice is prescribing, it has responsibility for checking that routine blood tests have been done (not necessarily by the practice) and for following up defaulters where responsibility has been accepted for administering treatment.

#### **MH 3.2 Reporting and Verification**

Practices should report the number of patients being prescribed lithium therapy by the practice. The practice should report the percentage of these patients who have had a serum lithium level in the last 6 months.

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

1. Inspection of the output from a computer search that has been used to provide information on this indicator
2. Inspection of a sample of records of patients prescribed lithium to look at the proportion with serum lithium levels in the last 6 months
3. Inspection of a sample of records of patients for whom a record of serum lithium in the last 6 months is claimed, to see if there is evidence of this in the medical records.

#### **Mental Health (MH) Indicator 4**

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

#### **MH 4.1 Rationale**

There is a much higher than normal incidence of hypercalcaemia and hypothyroidism in patients on lithium, and of abnormal renal function tests. Overt hypothyroidism has been found in between 8% and 15% of people on lithium.

#### **MH 4.2 Reporting and Verification**

MH 4.3.1 Practices should report the percentage of patients on lithium therapy with a record of TSH in the last 15 months.

MH 4.3.2 Practices should report the percentage of patients on lithium therapy with a record of serum creatinine in the last 15 months.

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

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

#### **Mental Health (MH) Indicator 5**

**The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the previous 6 months**

#### **MH 5.1 Rationale**

See MH 3.1

The therapeutic range for patients on lithium therapy is normally 0.6 - 1.0 mmol/l. If the range differs locally the PCO will be required to allow for this. Levels below 0.6 may be acceptable, depending on the clinical circumstances of the patient. For this reason, the top standard for this indicator has been set fairly low at 70%.

#### **MH 5.2 Reporting and Verification**

Practices should report the percentage of patients on lithium whose last serum lithium level is in the therapeutic range. The level should have been undertaken in the last 6 months.

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

1. Inspection of the output from a computer search that has been used to provide information on this indicator
2. Inspection of a sample of records of patients on lithium therapy to look at the proportion with recorded serum lithium between 0.6 and 1.0 mmol/l
3. Inspection of a sample of records of patients on lithium therapy for whom a record of serum lithium in the therapeutic range is claimed, to see if there is evidence of this in the medical records.

## Asthma

Indicator	Points	Payment stages
<b>Records</b>		
ASTHMA 1. The practice can produce a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the last twelve months	<b>7</b>	
<b>Initial Management</b>		
ASTHMA 2. The percentage of patients aged eight and over diagnosed as having asthma from 1 April 2003 where the diagnosis has been confirmed by spirometry or peak flow measurement	<b>15</b>	<b>25-70%</b>
<b>Ongoing management</b>		
ASTHMA 3. The percentage of patients with asthma between the ages of 14 and 19 in whom there is a record of smoking status in the previous 15 months	<b>6</b>	<b>25-70%</b>
ASTHMA 4. The percentage of patients aged 20 and over with asthma whose notes record smoking status in the past 15 months, except those who have never smoked where smoking status need be recorded only once since diagnosis	<b>6</b>	<b>25-70%</b>
ASTHMA 5. The percentage of patients with asthma who smoke, and whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered within the last 15 months	<b>6</b>	<b>25-70%</b>
ASTHMA 6. The percentage of patients with asthma who have had an asthma review in the last 15 months	<b>20</b>	<b>25-70%</b>
ASTHMA 7. The percentage of patients aged 16 years and over with asthma who have had influenza immunisation in the preceding 1 September to 31 March	<b>12</b>	<b>25-70%</b>

### Asthma - Rationale for Inclusion of Indicator Set

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

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

#### Asthma Indicator 1

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

#### Asthma 1.1 Rationale

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

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

One of the main difficulties in asthma is the variable and intermittent nature of asthma.

## Adults

Some of the symptoms of asthma are shared with diseases of other systems. Features of an airway disorder in adults such as cough, wheeze and breathlessness should be corroborated where possible by measurement of airflow limitation and reversibility.

Obstructive airways disease produces a decrease in peak expiratory flow (PEF) and forced expiratory volume in one second (FEV<sub>1</sub>). One or both of these should be measured, but may be normal if the measurement is made between episodes of bronchospasm. If they are repeatedly normal in the presence of symptoms, then a diagnosis of asthma must be in doubt.

Variability of PEF and FEV<sub>1</sub>, either spontaneously over time or in response to therapy, is a characteristic feature of asthma. Sequential measurement of PEF may be useful in making the diagnosis. A 20% or greater variability in amplitude with a minimum change of 60 l/min, ideally for three days in a week for two weeks seen over a period of time, is highly suggestive of asthma. As with other aspects of the framework, decisions about which patients actually have asthma and should therefore be included on the register are clinical ones which are intended to be made by individual GPs.

Many patients with asthma will demonstrate variability below 20%, making this a reasonably specific but insensitive diagnostic test. Marked variability of peak flow and easily demonstrated reversibility confirm a diagnosis of asthma but smaller changes do not necessarily exclude the diagnosis.

*SIGN/BTS British Guideline on the Management of Asthma*

## Children

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

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

The diagnosis of asthma in children should be based on:

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

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

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

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

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

## **Asthma 1.2 Reporting and Verification**

Asthma 1.3.1 Practices should report the number of patients with active asthma (ie a diagnosis of asthma, excluding those who have had no prescription issued for an asthma-related drug in the last 12 months), and the number of patients with active asthma (ie diagnosis of asthma, excluding those who have had no prescription issued for an asthma-related drug in the last 12 months) as a proportion of their practice list size.

Asthma 1.3.2 Practices should report the number of patients with inactive asthma (ie those who have a diagnosis of asthma who have had no asthma-related drug issued in the last 12 months) and the number of patients with inactive asthma (ie those who have a diagnosis of asthma who have had no asthma-related drug issued in the last 12 months) as a proportion of their practice list size.

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

#### **Asthma Indicator 2**

**The percentage of patients aged eight and over diagnosed as having asthma from 1 April 2003 where the diagnosis has been confirmed by spirometry or peak flow measurement**

#### **Asthma 2.1 Rationale**

The SIGN guideline suggests that confirmation of diagnosis by spirometry or serial peak flows should be utilised in schoolchildren, but does not specify an age. The age of eight has been pragmatically agreed for the indicator although many children aged six and over will be able to co-operate with PEF measurements or spirometry.

This indicator is introduced for diagnosis with effect from 1 April 2003 as it is recognised that recording to date may have not been undertaken in a systematic way.

#### **Asthma 2.2 Reporting and Verification**

The practice should report the percentage of patients aged eight or over diagnosed as having asthma after 1 April 2003 who have a record of spirometry or peak flow measurement.

#### **Asthma Indicator 3**

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

#### **Asthma 3.1 Rationale**

Two indicators have been included on the recording of smoking advice (Asthma 3 and Asthma 4). The two indicators, which relate to different age groups, have been included because GPs may take a different clinical approach to this issue at different ages. Many young people start to smoke at an early age. It is therefore justifiable to ask about smoking on an annual basis. Patients aged 20 and over fall into two categories: those who have never smoked, where recurrently asking about smoking status is inappropriate, and those who are smokers or ex-smokers where regular recording and offering of smoking cessation advice is appropriate. The indicators developed for the two age groups therefore differ: in adults who have a record of never having smoked, regular recording of smoking status is not recommended (indicator Asthma 4), whereas annual enquiry is recommended in children (indicator Asthma 3).

The number of studies of smoking related to asthma are surprisingly few in number. Starting smoking as a teenager increases the risk of persisting asthma. SIGN/BTS were unable to identify any study which considered the question of whether smoking affects asthma severity. One controlled cohort study suggested that exposure to passive smoke at home delayed recovery from an acute attack.

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

#### **Asthma 3.2 Reporting and Verification**

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

#### **Asthma Indicator 4**

**The percentage of patients aged 20 and over with asthma whose notes record smoking status in the past 15 months, except those who have never smoked where smoking status need be recorded only once since diagnosis**

#### **Asthma 4.1 Rationale**

See asthma 3.1

#### **Asthma 4.2 Reporting and Verification**

The aim of this indicator is to ensure that the smoking status of all patients is known in the previous year, making the assumption that patients who have never smoked will continue not to smoke (in order to avoid keeping asking them).

The numerator of the indicator is the number of asthma patients aged 20 and over who have never smoked plus the number who have been recorded as ex- or current smokers in the past 15 months. The denominator is the total number of asthma patients age 20 and over. Thus:

*% with smoking status recorded (among patients with asthma aged 20 and over) =*

*[no of never smoked] + [no recorded as ex- or current smokers in past 15 months]*

*\_\_\_\_\_*  
*[number with asthma aged 20 and over]*

#### **Asthma Indicator 5**

**The percentage of patients with asthma who smoke, and whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered within the last 15 months**

#### **Asthma 5.1 Rationale**

The evidence for the value of smoking cessation advice is largely extrapolated from studies in relation to CHD.

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

*Reference Grade B recommendation SIGN Guidelines 41/51*

Further Information: <http://www.sign.ac.uk/guidelines/fulltext/51/index.html>

Further Information: <http://www.sign.ac.uk/guidelines/fulltext/41/index.html>

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

Further Information: <http://www.nice.org.uk/pdf/NiceNRT39GUIDANCE.pdf>

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

## Asthma 5.2 Reporting and Verification

Practices should report the percentage of asthmatic patients who smoke who have been offered smoking cessation advice in the last 15 months.

### Asthma Indicator 6

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

#### Asthma 6.1 Rationale

Structured care has been shown to produce benefits for patients with asthma. The evidence on the important aspects of structured care is not good, although the recording of morbidity, PEF levels, inhaler technique and current treatment and the promotion of self-management skills are common themes. SIGN/BTS proposes a structured system for recording inhaler technique, morbidity, PEF levels, current treatment and asthma action plans.

*Reference Grade C Recommendation SIGN/BTS British Guideline on the Management of Asthma*

The Quality and Outcomes Framework suggests the utilisation of the RCP three questions as an effective way of assessing symptoms:

"In the last month

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

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

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

Inhaler technique should be reviewed but there is no evidence to suggest how frequently this should be undertaken.

#### Summary of Asthma Review:

- Assess symptoms (using RCP 3 questions)
- Measure peak flow
- Assess inhaler technique
- Consider personalised asthma plan

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

## **Asthma 6.2 Reporting and Verification**

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

### **Asthma Indicator 7**

**The percentage of patients with asthma aged 16 and over who have had influenza immunisation in the preceding 1 September to 31 March**

## **Asthma 7.1 Rationale**

There a current recommendation from the Departments of Health and the Joint Committee on Vaccination and Immunisation ([www.doh.gov.uk/greenbook/](http://www.doh.gov.uk/greenbook/)) which suggests that influenza immunisation should not be given under 6 months of age. While the guidance implies that all asthmatic children should be immunised annually from the age of 6 months, this advice is so far from common practice among GPs that this indicator refers to adults only at present.

## **Asthma 7.2 Reporting and Verification**

The percentage of patients on the asthma register aged 16 and over who have had an influenza immunisation administered in the preceding 1 September to 31 March.

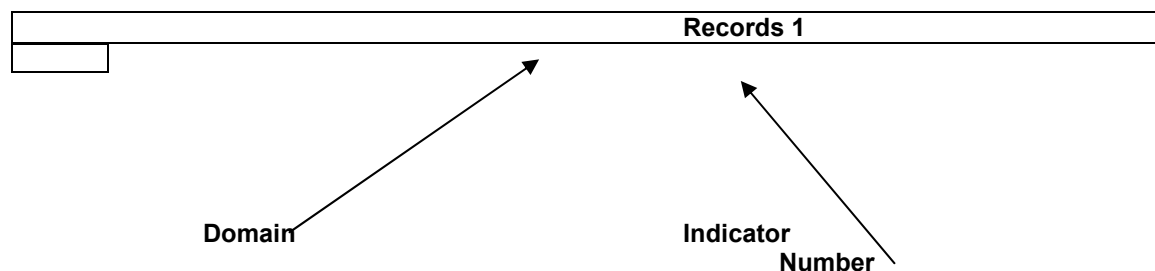
## Section 3: Organisational Indicators

### 1. Format

Organisational indicators are split into five domains:

- Records and information about patients (A)
- Information for patients (B)
- Education and training (C)
- Practice management (D)
- Medicines management (E)

Indicators are numbered as follows:



For each indicator (x) four descriptions are given:

#### X.1 Practice guidance

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

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

#### X.2 Written evidence

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

In summary, written evidence is categorised as follows:

- Grade A – to be submitted in advance of a visit
- Grade B – to be available in the practice at the visit
- Grade C – optional or used in the event of an appeal.

#### X.3 Assessment visit

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

#### X.4 Assessors' guidance

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

## **2. Equivalence – Other Schemes**

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

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

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

## Organisational Indicators – Records and Information About Patients (A)

### Summary of Indicators

Essential	A. Records and Information About Patients
<b>Records 1 1 point</b>	Each patient contact <b>with a clinician</b> is recorded in the patient's record, including consultations, visits and telephone advice
<b>Records 2 1 point</b>	Entries in the records are legible
<b>Records 3 1 point</b>	The practice has a system for transferring and acting on information about patients seen by other doctors out of hours
<b>Records 4 1 point</b>	There is a reliable system to ensure that messages and requests for visits are recorded and that the appropriate doctor or team member receives and acts upon them
<b>Records 5 1 point</b>	The practice has a system for dealing with any hospital report or investigation result which identifies a responsible health professional, and ensures that any necessary action is taken
<b>Records 6 1 point</b>	There is a system for ensuring that the relevant team members are informed about patients who have died
<b>Records 7 1 point</b>	The medicines that a patient is receiving are clearly listed in his or her record
<b>Records 8 1 point</b>	There is a designated place for the recording of drug allergies and adverse reactions in the notes and these are clearly recorded
<b>Records 9 4 points</b>	For repeat medicines, an indication for the drug can be identified in the records (for drugs added to the repeat prescription with effect from 1 April 2004). Minimum Standard 80%
<b>Records 10 6 points</b>	The smoking status of patients aged from 15 to 75 is recorded for at least 55% of patients
<b>Records 11 10 points</b>	The blood pressure of patients aged 45 and over is recorded in the preceding 5 years for at least 55% of patients
<b>Records 12 2 points</b>	When a member of the team prescribes a medicine, there is a mechanism for that prescription to be entered into the patient's general practice record
<b>Records 13 2 points</b>	There is a system to alert the out-of-hours service or duty doctor to patients dying at home
<b>Records 14 3 points</b>	The records, hospital letters and investigation reports are filed in date order or available electronically in date order
<b>Records 15 25 points</b>	The practice has up-to-date clinical summaries in at least 60% of patient records
<b>Records 16 5 points</b>	The smoking status of patients aged from 15 to 75 is recorded for at least 75% of patients
<b>Records 17 5 points</b>	The blood pressure of patients aged 45 and over is recorded in the preceding 5 years for at least 75% of patients
<b>Records 18 8 points</b>	The practice has up-to-date clinical summaries in at least 80% of patient records
<b>Records 19 7 points</b>	80% of newly registered patients have had their notes summarised within 8 weeks of receipt by the practice

#### Records Indicator 1

**Each patient contact with a clinician is recorded in the patient's record, including consultations, visits and telephone advice**

#### Records 1.1 Practice guidance

Compliance with this indicator will help practices to meet the recommendations of "Good Medical Practice for General Practitioners". This is also recommended as good practice by the Medical Defence Organisations. GP-employed nurses should refer to the Nursing and Midwifery Council (NMC) guidelines on records and record-keeping ([www.nmc-uk.org](http://www.nmc-uk.org)).

Most practices record consultations and visits in the patient records. It should be noted that telephone advice given by clinicians should also be recorded and the practice should have a system to ensure this happens. The receptionists may be questioned at a monitoring visit on whether this happens.

Records can be on paper or on computer.

#### **Records 1.2 Written evidence**

Each practice should have a policy on recording contacts with clinicians in the practice (Grade C).

#### **Records 1.3 Assessment visit**

Clinical staff could be questioned as to how contacts are recorded.

#### **Records 1.4 Assessors' guidance**

If a patient phones for advice, how is this recorded in the notes?  
All patient contacts need to be recorded.

### **Records Indicator 2**

#### **Entries in the records are legible**

#### **Records 2.1 Practice guidance**

Good Medical Practice for General Practitioners states that "paper records should be legible". Actions can more easily be defended if records are legible.

If the clinical records are held on computer the practice should have no problems with this indicator. If the practice considers it difficult to read any of the writing in the records steps should be taken to overcome this. An external assessor may have more difficulty than any member of the team, as team members become familiar over time with interpreting a colleague's writing. Examples of compliance might involve asking the poor writer to print the diagnosis, management or therapy, having typed entries for all or some clinical staff or moving to a computer-based record system.

#### **Records 2.2 Written evidence**

Each practice should provide the results of a survey of patient records (minimum 50) recording their understandability (for definition see Records 2.3). (Grade A)

#### **Records 2.3 Assessment visit**

A random sample of 20 notes will be inspected to confirm the understandability of the clinical entry.

#### **Records 2.4 Assessors' guidance**

If one assessor can read the entries made in the past year the criterion is passed. The important elements are diagnosis, management and therapy. If the meaning of these elements is not clear in more than one entry in the past year where they should be present, then the criterion is not passed. Doctors who have subsequently left the practice including GP registrars can be excluded. Locums who have worked occasionally in the practice can be excluded, but those who undertake regular sessions should be included.

### **Records Indicator 3**

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

### **Records 3.1 Practice guidance**

Good Medical Practice for General Practitioners states that the excellent GP “can demonstrate an effective system for transferring and acting on information from other doctors about patients”. Out-of-hours reviews in England and Scotland have emphasised the importance of the effective transfer of information.

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

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

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

### **Records 3.2 Written evidence**

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

### **Records 3.3 Assessment visit**

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

### **Records 3.4 Assessors’ guidance**

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

## **Records Indicator 4**

**There is a reliable system to ensure that messages and requests for visits are recorded and that the appropriate doctor or team member receives and acts upon them**

### **Records 4.1 Practice guidance**

One recognised area of risk in general practice is message-taking; hence it is important to ensure that there is a robust system.

The system should not rely on word of mouth or “post-it pads”. All receptionists should have full knowledge of the system.

### **Records 4.2 Written evidence**

A description of the system for message-taking and requests for visits is required. (Grade C)

### **Records 4.3 Assessment visit**

Inspection of the system of message taking and requests for visits may be carried out.

### **Records 4.4 Assessors’ guidance**

The receptionists should be observed where possible when they receive a message on the telephone. The system whether it be paper-based or computer-held should be inspected. Interviews with reception and clinical staff may be carried out.

## **Records Indicator 5**

**The practice has a system for dealing with any hospital report or investigation result which identifies a responsible health professional, and ensures that any necessary action is taken**

### **Records 5.1 Practice guidance**

To decrease the risk of error it is important that a system for dealing with incoming hospital reports and investigation results is in place. Many practices which receive paper reports or results use a stamp on incoming mail to ensure action is taken. The health professional who takes the decision should also be identifiable eg by initialling the action to be taken. Those receiving electronic mail should ensure that an equivalent system is in place.

### **Records 5.2 Written evidence**

There should be a description of the system for reviewing and actioning any investigation or letter. (Grade A)

### **Records 5.3 Assessment visit**

The visit should allow inspection, of the system for reviewing and actioning any investigation report or hospital letter.

### **Records 5.4 Assessors' guidance**

The system should ensure that all abnormal results are identified and acted on.

## **Records Indicator 6**

**There is a system for ensuring that the relevant team members are informed about patients who have died**

### **Records 6.1 Practice guidance**

It is most distressing to bereaved relatives if members of the team do not know of a patient's death.

Constructing a procedure for receptionists on what do to do when a death is notified to them is important. The key element of the system is notification of relevant members of the primary care team about the death.

### **Records 6.2 Written evidence**

There should be a description of the system for informing team members of a patient's death. (Grade C)

### **Records 6.3 Assessment visit**

The receptionists might be asked to demonstrate the system of what they do when notified of the death of a patient.

### **Records 6.4 Assessors' guidance**

An example of how information was transferred following a recent death might be examined.

**Records Indicator 7****The medicines that a patient is receiving are clearly listed in his or her record****Records 7.1 Practice guidance**

Good Medical Practice for General Practitioners states: "The records of patients on long term medication should include a clear summary of medication".

This indicator applies to all prescriptions, acute and repeat, but only repeat prescriptions will be assessed.

If the computer is used for issuing and recording repeat prescriptions then this criterion is easily achieved.

If paper records only are kept, then a separate sheet may be kept as one method of listing the repeat medication.

**Records 7.2 Written evidence**

The practice should describe how prescribed medication is recorded. (Grade C)

**Records 7.3 Assessment visit**

A search of patient records might be conducted.

**Records 7.4 Assessors' guidance**

Drug therapy refers to repeat medication as far as the assessment is concerned.

**Records Indicator 8****There is a designated place for the recording of drug allergies and adverse reactions in the notes and these are clearly recorded****Records 8.1 Practice guidance**

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

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

**Records 8.2 Written evidence**

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

**Records 8.3 Assessment visit**

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

**Records 8.4 Assessors' guidance**

The place where drug allergies are recorded can be on the computer or in the paper records. This information should be easily available to the prescribing clinician at the time of consultation.

**Records Indicator 9****For repeat medicines, an indication for the drug can be identified in the records (for drugs added to the repeat prescription with effect from 1 April 2004)****Minimum Standard 80%**

### **Records 9.1 Practice guidance**

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

It is recognised that most practices utilise computer systems for repeat prescriptions and it is intended that an IT solution will be available to assist practices in meeting this indicator. The start date for this indicator has therefore been delayed to 1 April 2004 as not all GP clinical IT systems can link diagnosis to repeat prescriptions. A system for doing this will need to be initiated in many practices when the software has been modified. This criterion will not be assessed until after 1 April 2004.

In practices where the computer is not utilised for repeat prescriptions, the clinician should write clearly in the patient record the diagnosis relating to the prescription. This need only be done once when the medication is initiated.

The survey to show compliance should be a minimum of 50 patients who have been commenced on a new repeat prescription from 1 April 2004.

### **Records 9.2 Written evidence**

A survey of the drugs used should be carried out. The survey should show an indication can be identified for at least 80% of repeat medications commenced after 1<sup>st</sup> April 2004. (Grade A)

### **Records 9.3 Assessment visit**

The records should be inspected.

### **Records 9.4 Assessors' guidance**

As part of the inspection of records those drugs which have been added to the repeat prescription from 1 April 2004 should be identified and an indication for starting them should be clear. The help of practice staff may be required to achieve this. The records of twenty patients for whom repeat medication has been started since that date should be surveyed. If the standard is not achieved then a further twenty clinical records should be surveyed and the cumulative total should be used. The minimum standard is that 80% of the indications for repeat medication drugs can be identified.

## **Records Indicator 10**

**The smoking status of patients aged from 15 to 75 is recorded for at least 55% of patients**

### **Records 10.1 Practice guidance**

There is evidence that when doctors and other health professionals advise patients to stop smoking, this is effective. This indicator examines whether smoking status is recorded in the clinical record.

Dependent on how practices record smoking status, the survey can be undertaken by computer search or a survey of the written records.

Although smoking status recorded ever is sufficient to fulfil this criterion, it is good practice to ask smokers their status on a regular basis.

A similar indicator is proposed as Records Indicator 16 but a higher standard must be achieved.

### **Records 10.2 Written evidence**

A survey of written records or a computer search of patients aged from 15 to 75 years should be carried out (surveying a minimum of 50 records), to determine the percentage where smoking habit is recorded at least once. (Grade A)

### **Records 10.3 Assessment visit**

A random sample of 20 notes or computerised records of patients aged from 15 to 75 should be inspected, to confirm that smoking status is recorded at least once.

### **Records 10.4 Assessors' guidance**

The practice's own survey is verified by inspecting 20 patient records at the visit. If the result differs from the practice survey then a further 20 patient records should be checked.

### **Records Indicator 11**

**The blood pressure of patients aged 45 and over is recorded in the preceding 5 years for at least 55% of patients**

### **Records 11.1 Practice guidance**

Detecting elevated blood pressure and treating it is known to be an effective health intervention. The limit to patients aged 45 and over has been pragmatically chosen as the vast majority of patients develop hypertension after this age. It is anticipated that practices will opportunistically check blood pressures in all adult patients.

Depending on whether practices record blood pressure in the computer or manual record, the survey can be undertaken by computer search or a survey of the written records.

A similar indicator is proposed as Records Indicator 17 but a higher standard must be achieved.

### **Records 11.2 Written evidence**

A survey of the records of patients aged 45 and over (a minimum of 50 records) or a report from a computer search should be carried out, showing that blood pressure has been recorded in last 5 years. (Grade A)

### **Records 11.3 Assessment visit**

A random sample of 20 notes or computerised records of patients aged 45 and over should be inspected, to confirm that blood pressure has been recorded in last 5 years.

### **Records 11.4 Assessors' guidance**

The practice's own survey may be verified by inspecting 20 clinical records of patients aged 45 and over at the visit. If the result differs from the practice survey, then a further 20 records need to be checked.

### **Records Indicator 12**

**When a member of the team prescribes a medicine, there is a mechanism for that prescription to be entered into the patient's general practice record**

### **Records 12.1 Practice guidance**

Nurse prescribing is increasing and expanding. It is important that all prescribed medicines are recorded in the clinical record. This should include all medications prescribed by any team member.

Useful references are 'Nurse Prescribing: a guide for implementation' 1998 [concerning district nurse/health visitor prescribing] and 'Extending Independent Nurse Prescribing within the NHS in England: a guide for implementation' March 2002 [concerning extended formulary nurse prescribing].

### **Records 12.2 Written evidence**

There should be a statement as to how prescriptions are recorded, and in particular how nurse-initiated prescriptions are recorded. (Grade C).

### **Records 12.3 Assessment visit**

A sample of records should be inspected.

### **Records 12.4 Assessors' guidance**

Nurse prescribers should be questioned on the system for entering prescriptions in patients' records and the system should be checked with any other members of the team involved.

### **Records Indicator 13**

**There is a system to alert the out-of-hours service or duty doctor to patients dying at home**

### **Records 13.1 Practice guidance**

Good Medical Practice states that when off duty the doctor ensures there are arrangements which "include effective hand-over procedures and clear communication between doctors". It is especially important for patients who are terminally ill and likely to die in the near future at home or where clinical management is proving difficult or challenging.

The practice should have developed a system with their out-of-hours care provider to transfer information from the practice to that provider about patients that the attending doctor anticipates may die from a terminal illness in the next few days and hence may require medical services in the out-of-hours period. If a practice does its own on call duties then a system should ensure that all doctors in the practice are aware of these patients. A single-handed doctor who usually covers his or her own patients out of hours should have a similar system in place when he or she is absent from the practice eg on holiday.

### **Records 13.2 Written evidence**

The system for alerting the out-of-hours service or duty doctor to patients dying at home should be described. (Grade C)

### **Records 13.3 Assessment visit**

The doctors in the practice should be questioned on the system that is in place.

### **Records 13.4 Assessors' guidance**

The team should be questioned on their system by asking for recent examples of patients who have been terminally ill, dying at home and what information was passed to the out-of-hours service or duty doctor.

### **Records Indicator 14**

**The records, hospital letters and investigation reports are filed in date order or available electronically in date order**

**Minimum Standard 80%**

### **Records 14.1 Practice guidance**

Good Medical Practice for General Practitioners states that the excellent doctor "files GP notes, hospital letters, and investigation reports in date order".

Any combination of paper and computer records is allowable.

#### **Records 14.2 Written evidence**

A survey of patient records (minimum 50) should be carried out, recording the percentage of records, hospital letters and investigations are filed in date order. A minimum of 80% is to be achieved. (Grade A)

#### **Records 14.3 Assessment visit**

A random sample of 20 clinical records should be examined to confirm the percentage of records in which the hospital letters and investigations are filed in date order.

#### **Records 14.4 Assessors' guidance**

The practice's own survey is verified by inspecting 20 clinical records. If the result differs from the practice survey then a further 20 records need to be checked.

<b>Records Indicator 15</b>
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<b>The practice has up-to-date clinical summaries in at least 60% of patient records</b>
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#### **Records 15.1 Practice guidance**

Good Medical Practice for General Practitioners states "Important information in records should be easily accessible, for example, as part of a summary."

If a system for producing summaries is not in place then this will involve a great deal of work. The practice will need to decide which conditions it will include in the summary. The practice would be expected to have a policy on what is included in a summary. All significant past and continuing problems should be included.

If a computer is used the practice will need to decide which Read codes to use for common conditions. It is best to use a set of codes that has been agreed within a PCO or nationally to allow comparison and exchange of data.

A similar indicator is proposed as Records 18 but a higher standard must be achieved.

#### **Records 15.2 Written evidence**

A survey of patient records (minimum 50) should be carried out, recording the percentage that have clinical summaries and the percentage which are up to date. (Grade A)

#### **Records 15.3 Assessment visit**

A random sample of 20 patient records should be examined to confirm the percentage that have clinical summaries and the percentage which are up to date.

#### **Records 15.4 Assessors' guidance**

The practice's own survey is verified by inspecting 20 clinical records. If the result differs from the practice survey then a further 20 records need to be checked. Assessors may need to clarify with the practice what information they would normally include in a clinical summary ensuring that they do not assess this indicator based on their own experience and beliefs.

<b>Records Indicator 16</b>
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<b>The smoking status of patients aged from 15 to 75 is recorded for at least 75% of patients</b>
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#### **Records 16.1 Practice guidance**

See Records 10.1.

**Records 16.2 Written evidence**

See Records 10.2. (Grade A)

**Records 16.3 Assessment visit**

See Records 10.3.

**Records 16.4 Assessors' guidance**

See Records 10.4.

**Records Indicator 17**

**The blood pressure of patients aged 45 and over is recorded in the preceding 5 years for at least 75% of patients**

**Records 17.1 Practice guidance**

See Records 11.1.

**Records 17.2 Written evidence**

See Records 11.2. (Grade A)

**Records 17.3 Assessment visit**

See Records 11.3.

**Records 17.4 Assessors' guidance**

See Records 11.4.

**Records Indicator 18**

**The practice has up-to-date clinical summaries in at least 80% of patient records**

**Records 18.1 Practice guidance**

See Records 15.1.

**Records 18.2 Written evidence**

See Records 15.2. (Grade A)

**Records 18.3 Assessment visit**

See Records 15.3.

**Records 18.4 Assessors' guidance**

See Records 15.4.

**Records Indicator 19**

**80% of newly registered patients have had their notes summarised within 8 weeks of receipt by the practice**

**Records 19.1 Practice guidance**

The criterion refers to the time the notes have been received by the practice and not the time of registration. For some practices that take on many patients at a set time of year achievement of the indicator will require some forward planning.

Read codes may be utilised to record this information and can then be searched for on the practice computer system.

**Records 19.2 Written evidence**

A survey should be carried out of the records of newly registered patients whose notes have been received between 8 and 26 weeks previously (either a sample of 30 or all patients if there have been fewer than 30 such registrations), noting if the records have been received and summarised.

Alternatively a computer print-out should be examined, showing the patients registered where the records have been received between 8 and 26 weeks previously, to confirm whether the computer record contains a clinical summary. (Grade A)

**Records 19.3 Assessment visit**

A sample of 20 records of patients whose records were sent to the practice between by the PCO between 9 and 26 weeks ago should be examined, to ascertain if the records have arrived and have been summarised.

**Records 19.4 Assessors' guidance**

A list of patients registered in the past 12 months and whose records have been forwarded between 9 and 26 weeks ago to the practice will be obtained from the PCO. A sample of 20 records, or all if there have been fewer of these patients, will be checked. If the result differs significantly (at least 10%) from the practice survey a further 20 records will be checked if appropriate.

## Organisational Indicators – Information for Patients (B)

### Summary of Indicators

<b>B. Information for Patients</b>	
<b>Information 1 0.5</b>	The practice has a system to allow patients to contact the out-of-hours service by making no more than two telephone calls
<b>Information 2 0.5 points</b>	If an answering system is used out of hours, the message is clear and the contact number is given at least twice
<b>Information 3 1 point</b>	The practice has arrangements for patients to speak to GPs and nurses on the telephone during the working day
<b>Information 4 1 point</b>	If a patient is removed from a practice's list, the practice provides an explanation of the reasons in writing to the patient and information on how to find a new practice, unless it is perceived that such an action would result in a violent response by the patient
<b>Information 5 2 points</b>	The practice supports smokers in stopping smoking by a strategy which includes providing literature and offering appropriate therapy
<b>Information 6 0.5 points</b>	Information is available to patients on the roles of the GP, community midwife, health visitor and hospital clinics in the provision of ante-natal and post-natal care
<b>Information 7 1.5 points</b>	Patients are able to access a receptionist via telephone and face to face in the practice, for at least 45 hours over 5 days, Monday to Friday, except where agreed with the PCO
<b>Information 8 1 point</b>	The practice has a system to allow patients to contact the out-of-hours service by making no more than one telephone call

#### Information Indicator 1

**The practice has a system to allow patients to contact the out-of-hours service by making no more than two telephone calls**

#### Information 1.1 Practice guidance

In an emergency, it is important that a patient can contact a clinician quickly. This was a recommendation of out-of-hours reviews in both Scotland and England.

A practice should ensure that its system does not include any additional telephone calls for patients to make over and above the two calls stated in the indicator. This may be particularly relevant in areas where contacting the duty doctor may involve phoning the practice, then the doctor's home, and then a mobile phone number.

#### Information 1.2 Written evidence

The system for contacting the out-of-hours service should be described. (Grade C)

#### Information 1.3 Assessment visit

The practice should be telephoned after 6.30 pm on a weekday, or at some other time during the out-of-hours period.

#### Information 1.4 Assessors' guidance

The practice should be telephoned after 6.30 pm on a weekday, or at some other time during the out-of-hours period, to confirm that no more than two telephone calls are needed to contact the out-of-hours service. This confirmation will need to have taken place prior to the visit.

## **Information Indicator 2**

**If an answering system is used out of hours, the message is clear and the contact number is given at least twice**

### **Information 2.1 Practice guidance**

It is useful for the answering system message to be clearly posted near the telephone so that all staff are aware of the approved wording. This minimises the risk of staff re-recording the message and changing the agreed format. Patients with hearing impairment find messages with background noise, eg ringing phones etc, difficult to hear. Staff or doctors should be encouraged to speak slowly when recording the message. This indicator will only be assessed if an answering system is used.

If the practice does not use the answer machine then it would be exempt from this indicator.

### **Information 2.2 Written evidence**

The practice will state the exact message used. (Grade C)

### **Information 2.3 Assessment visit**

The answering system will be demonstrated.

### **Information 2.4 Assessors' guidance**

The assessor should listen to the message in order to confirm that background noise on the tape does not obscure the message and that the number is clear and repeated at least twice. This can be checked along with Information Indicator 1.

## **Information Indicator 3**

**The practice has arrangements for patients to speak to GPs and nurses on the telephone during the working day**

### **Information 3.1 Practice guidance**

Good Medical Practice for General Practitioners states that the excellent GP "has a system for receiving or returning phone calls from patients" and that the unacceptable GP "provides no opportunity for patients to talk to a doctor or a nurse on the phone".

Some practices have specific times to speak to a clinician and others make arrangements for the clinician to phone the patient back.

It is useful for this information to be advertised to patients eg through the practice leaflet, notices in the practice, slips given to patients when being asked to phone back for a result, the tear-off side of a prescription, the practice newsletter etc.

### **Information 3.2 Written evidence**

The practice has a written policy on telephone availability (Grade A)

### **Information 3.3 Assessment visit**

The assessors should seek out evidence on when the practice team is available to answer telephone calls by checking practice leaflets, observing the office and asking reception and clinical staff.

### **Information 3.4 Assessors' guidance**

The receptionists should be able to respond positively to a request by a patient to speak to a clinician on the telephone. The assessors should confirm with reception staff the information they give patients who require to speak to a GP or practice-employed nurse. Patients do not require to speak to a clinician immediately unless it is an emergency, but at least one clinician in the practice should be available every working day. The assessors should confirm with staff how patients are informed of the policy and check the stated sources, eg practice leaflet, notices at the reception desk or in the waiting area, etc.

#### **Information Indicator 4**

**If a patient is removed from the practice's list, the practice provides an explanation of the reasons in writing to the patient and information on how to find a new practice, unless it is perceived that such an action would result in a violent response by the patient**

### **Information 4.1 Practice guidance**

It is good practice to explain to a patient the reasons for being removed from the list. This is the recommendation of both the BMA and the RCGP. Normally, this will be based on a perceived breakdown in the doctor/patient relationship but it will often be useful to give a fuller explanation than simply stating this. The letter should not normally be a standard letter of removal but tailored to the individual situation. The reason for removal should not be solely that a patient has made a complaint against the practice (see Good Medical Practice for General Practitioners).

Many patients will not be aware of the procedure for registration with another practice and will not be aware that the Primary Care Organisation can assist them. They should be given relevant guidance and contact details.

In exceptional circumstances, it will be felt that a written explanation of the reasons for removal for the list will further inflame a difficult situation, potentially endangering the safety of practice team members. In these circumstances, the omission of a written explanation will be justified. It may be useful to discuss this issue and include guidance in the practice's policy.

### **Information 4.2 Written evidence**

There should be a written policy on removing patients from the list. (Grade B)

### **Information 4.3 Assessment visit**

The written policy statement should be inspected or the practice team should be questioned on the policy.

### **Information 4.4 Assessors' guidance**

The practice should submit a written policy. It may also be useful to check with team members that the policy is consistently used. Patients should normally be given a written reason for their removal and the letter should contain both the elements in the criterion.

#### **Information Indicator 5**

**The practice supports smokers in stopping smoking by a strategy which includes providing literature and offering appropriate therapy**

### **Information 5.1 Practice guidance**

There is good evidence about the effectiveness of healthcare professionals in assisting patients to stop smoking.

A number of studies have recently shown benefits from the prescription of nicotine replacement therapy or bupropion in patients who have indicated a wish to quit smoking.

Further Information: <http://www.nice.org.uk/pdf/NiceNRT39GUIDANCE.pdf>

The strategy does not need to be written by the practice team. A local or national protocol could be adapted for use specifically by the practice and implemented. The provision of dedicated smoking cessation services remains the responsibility of the PCO.

#### **Information 5.2 Written evidence**

There should be a practice protocol concerning smoking cessation. (Grade A)

#### **Information 5.3 Assessment visit**

Prescribing data should be reviewed, and literature available for patients who wish to quit should be examined.

#### **Information 5.4 Assessors' guidance**

The strategy should take into account current evidence in this area. Signs of implementation may be evident in the practice's prescribing data or in the patient leaflets that are used by the practice.

### **Information Indicator 6**

**Information is available to patients on the roles of the GP, community midwife, health visitor and hospital clinics in the provision of ante-natal and post-natal care**

#### **Information 6.1 Practice guidance**

The provision of information to patients which clearly defines the roles of the team members involved in their care will contribute to their satisfaction with the service and help them to use it appropriately. It is particularly useful if the information can name the individuals who may be involved in the patient's care.

#### **Information 6.2 Written evidence**

The practice gives ante-natal patients written information on the roles of each member of the practice team. (Grade B)

#### **Information 6.3 Assessment visit**

The information given to ante-natal patients should be inspected.

#### **Information 6.4 Assessors' guidance**

The availability of copies of information given to ante-natal patients should be checked with team members.

### **Information Indicator 7**

**Patients are able to access a receptionist via telephone and face to face in the practice, for at least 45 hours over 5 days, Monday to Friday, except where agreed with the PCO**

#### **Information 7.1 Practice guidance**

Good Medical Practice for General Practitioners states "patients appreciate being able to contact the surgery throughout the working day." To satisfy this indicator, reception staff will have to be available face to face and on the telephone for the stated hours, spread through Monday to Friday. This indicator may be difficult and inappropriate to satisfy in some single-handed and remote and rural practices. In these circumstances, the level of receptionist cover should be agreed with the PCO. The practice should have written confirmation that this level of cover has been agreed.

### **Information 7.2 Written evidence**

There should be a written summary of the times when telephone/face-to-face access to receptionists is available. (Grade A)

### **Information 7.3 Assessment visit**

Reception staff should be questioned concerning the arrangements for access to receptionists.

### **Information 7.4 Assessors' guidance**

Assessors should confirm with reception staff that their hours of work as a team cover the hours of telephone and face-to-face availability as stated in the summary. In single-handed or remote and rural practices where it is not appropriate or possible to provide this amount of cover, the practice should have available written confirmation from the PCO of the agreed level of coverage.

### **Information Indicator 8**

**The practice has a system to allow patients to contact the out-of-hours service by making no more than one telephone call**

### **Information 8.1 Practice guidance**

This is an aspiration of the Carson report on out-of-hours care in England. The Scottish review on out-of-hours services also recommends that, ideally, those services should be contactable by making no more than one telephone call.

It is recognised that this may put an additional burden on out-of-hours services and the introduction of this indicator will be linked to the movement of responsibility for out-of-hours care to PCOs in April 2004.

The ability to do this will depend on the technology available. If this is not available in a practice area, then exemption may be applied for from the PCO.

Practices should ensure that their system does not include a requirement that patients should make additional telephone calls over and above the one call stated in the criterion. This may be particularly relevant in areas where contacting the duty doctor may involve phoning the practice, then the doctor's home, and then being passed to a mobile phone number. If, in order to satisfy this indicator, the practice has to leave another number on the answering system, please refer also to Information Indicator 2 regarding the quality of the message.

### **Information 8.2 Written evidence**

No written evidence is required.

### **Information 8.3 Assessment visit**

The practice should be telephoned after 6.30 pm.

### **Information 8.4 Assessors' guidance**

The practice should be telephoned after 6.30 pm to confirm that no more than one telephone call is needed to contact the out-of-hours service. This phone call should take place prior to the visit. Exemptions agreed by the PCO will need to be specified in writing.

## Organisational Indicators – Education and Training (C)

### Summary of Indicators

<b>C. Education and Training</b>	
<b>Education 1 4 points</b>	There is a record of all practice-employed clinical staff having attended Training/updating in basic life support skills in the preceding 18 months
<b>Education 2 4 points</b>	The practice has undertaken a minimum of six significant event reviews in the past 3 years
<b>Education 3 2 points</b>	All practice-employed nurses have an annual appraisal
<b>Education 4 3 points</b>	All new staff receive induction training
<b>Education 5 3 points</b>	There is a record of all practice-employed staff having attended training/updating in basic life support skills in the preceding 36 months
<b>Education 6 3 points</b>	The practice conducts an annual review of patient complaints and suggestions to ascertain general learning points which are shared with the team
<b>Education 7 4 points</b>	The practice has undertaken a minimum of twelve significant event reviews in the past 3 years which include (if these have occurred): <ul style="list-style-type: none"> <li>• Any death occurring in the practice premises</li> <li>• Two new cancer diagnoses</li> <li>• Two deaths where terminal care has taken place at home</li> <li>• One patient complaint</li> <li>• One suicide</li> <li>• One section under the Mental Health Act</li> </ul>
<b>Education 8 3 points</b>	All practice-employed nurses have personal learning plans which have been reviewed at annual appraisal
<b>Education 9 3 points</b>	All practice-employed non-clinical team members have an annual appraisal

#### Education Indicator 1

**There is a record of all practice-employed clinical staff having attended training/updating in basic life support skills in the preceding 18 months**

#### Education 1.1 Practice guidance

The primary care team members deal with cardio-pulmonary collapse relatively rarely, but require to have up-to-date skills to deal with an emergency. This is best undertaken at regular intervals through practical skills-based training sessions, as it is known that these skills diminish after a relatively short time. The timescale has been set pragmatically at 18 months, although many practices offer training on a more frequent basis.

This training may be available from a variety of providers including your local Accident and Emergency Department, BASICS, the PCO, out-of-hours co-operative, Red Cross, St John's Ambulance or equivalent. It may be sufficient for one individual in the team to attend for external training and then cascade this within the team.

#### Education 1.2 Written evidence

Attendance at CPR training should be listed. (Grade B)

#### Education 1.3 Assessment visit

Staff should be questioned on the date of their last CPR training.

#### Education 1.4 Assessors' guidance

Assessors should confirm by checking the CPR attendance list that practice-employed clinical staff have attended.

## Education Indicator 2

The practice has undertaken a minimum of six significant event reviews in the past 3 years

### Education 2.1 Practice guidance

Significant event review is a recognised methodology for reflecting on important events within a practice and is an accepted process as evidence for GMC revalidation.

Significant event analysis is not new, although its terminology may have changed. It was first known as critical event monitoring. It provides structure to an activity which anyway happens informally between health care professionals. It is the discussion of cases and events and the learning obtained through reflection. Due to its reflective nature, it can be viewed as an extension of audit activity. Discussion of specific events can provoke emotions that can be harnessed to achieve change. For it to be effective, it needs to be practised in a culture that avoids blame allocation and involves all disciplines within the practice.

The following steps are useful in introducing significant event analysis to a practice:

1. A multidisciplinary meeting to explain the concept.
2. Consideration of events which should be important to the practice but need not imply criticism of the practice. The practice can construct a core list as a basis to stimulate discussion or it can use the one published in the RCGP Occasional Paper (see reference at end of this section). Some of the examples from this are below.

Preventative care:	Measles Unplanned pregnancy Non-accidental injury Squint diagnosed by an ophthalmologist
Acute care:	Sudden unexpected death Death occurring on the practice premises Suicide or suicide attempt All new cancer diagnoses Myocardial Infarction Terminal care death at home Section under Mental Health Act
Chronic disease:	Diabetic hypoglycaemia Leg ulcer or amputation Asthma - hospitalisation Epilepsy – status epilepticus
Organisation:	Investigation received but not acted upon Breach of confidentiality Any patient complaints Upsetting of staff

3. Mechanism for identification of events. A logbook kept at reception may be helpful or an electronic logbook held on the practice computer system. Any mechanism should allow all team members to contribute.
4. Significant events meetings. These are generally multidisciplinary but need not be so and are chaired. Notes should be taken but should not include patient identification. Each attendee should be encouraged to take along at least one significant event. The meeting can choose which to discuss first and anybody can have the right to veto if that area is considered too sensitive.

The events are then discussed, first highlighting the aspects of high standard and then those standards that can be improved. A decision about the case needs to be reached.

This can be:

- celebration of excellent care
- no change
- audit required
- Immediate change required.

Follow-up of these decisions should be arranged and this may occur at the next significant event analysis meeting.

These reports should be laid out in a form consistent with either of the two following suggested formats:

A.

- **Description of event.** This should be brief and can be in note form.
- **Learning outcome.** This should describe the aspects which were of high standard and those which could be improved. Where appropriate it should include why the event occurred.
- **Action plan.** The decision(s) taken need to be contained in the report. The reasons for these decisions should be described together with any other lessons learned from the discussion.

B.

- What happened?
- Why did it happen?
- Was insight demonstrated?
- Was change implemented?

Reference:

Royal College of General Practitioners. *Significant Event Auditing: Occasional Paper 70*. London: RCGP, 1995.

A description of significant event audit is also available in: Robinson LA, Stacy R, Spencer JA, Bhopal RS. *How To Do It: Use facilitated case discussions for significant event auditing*. *BMJ* 1995; 311: 315-318.

### **Education 2.2 Written evidence**

Each case report must consist of a short commentary setting out the relevant history, the circumstances of the episode and an analysis of the conclusions to be drawn. Evidence should be presented of any clinical and organisational changes resulting from the analysis of these cases. (Grade A)

### **Education 2.3 Assessment visit**

The reviews should be discussed.

### **Education 2.4 Assessors' guidance**

The practice should report their analyses in a form consistent with either of the two following methods:

- A. Statement of the problem or event, learning outcome and action plan **OR**
- B. What happened? Why did it happen? Was insight demonstrated? Was change implemented?

The practice should involve, where ever possible, all team members who were stakeholders in the event in the case discussion.

<b>Education Indicator 3</b>
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<b>All practice-employed nurses have an annual appraisal</b>
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### **Education 3.1 Practice guidance**

Appraisal is a constructive opportunity to review performance objectives, progress and skills and identify learning needs in a protected environment. The learning needs identified may be personal to the appraisee and/or organisational learning needs which the appraisee has agreed to fulfil. The outcome of the appraisal should be a written action plan agreed between appraiser and appraisee which could include a personal learning plan for the appraisee.

Practices which have established appraisal schemes for the nursing team use varying professionals as appraisers. The agreed structure of the scheme should include identification of which individual(s) will take on the role of appraiser. It is important that all team members who are appraisers are adequately trained in appraisal techniques.

Some further guidance on appraisal can be found on the ACAS website ([www.acas.org.uk](http://www.acas.org.uk)) and in the ACAS advisory booklet: Employee Appraisal. <http://www.acas.org.uk/publications/B07.html>

The practice could draw on the professional practice and appraisal skills of a lead nurse in the PCO.

### **Education 3.2 Written evidence**

The appraisal system should be described. (Grade C)

### **Education 3.3 Assessment visit**

The doctors and practice-employed nurses should be questioned on the nurses' appraisals.

### **Education 3.4 Assessors' guidance**

The appraisal system for practice-employed nurses should be discussed with the nurses themselves and the person responsible for managing the appraisal scheme eg GPs, nurse, practice manager. The appraisal content is confidential and should not be discussed at the visit.

## **Education Indicator 4**

### **All new staff receive induction training**

### **Education 4.1 Practice guidance**

The use of a structured induction programme will help new staff fit more quickly into the practice and support them in becoming effective team members. It is useful to establish a programme of induction for a post, but to remember that it may need to be used flexibly, for example when an employee:

- is returning to work after a long absence
- has not worked before
- has a disability
- is from an ethnic minority group.

A programme could include:

- going through terms and conditions of employment
- meeting other members of the practice team, possibly including shadowing
- clarifying areas of responsibility and accountability
- practice codes and/or standards and regulations including Health and Safety/special hazards, uniforms, arrangements for working overtime, time in lieu etc
- familiarisation with protocols and procedures including employment procedures eg sickness absence policy
- training in the responsibilities of the post.

This list is not exhaustive.

Clear recording of the areas covered in the programme and regular reviews of progress will help establish the standard of performance which is expected and help the manager and new member of staff to identify

remaining areas of lack of knowledge and understanding. This will help the new team member to feel valued and supported.

#### **Education 4.2 Written evidence**

If a new member of staff has commenced after 1 April 2003, a copy of the induction programme which has been implemented should be available. (Grade B)

#### **Education 4.3 Assessment visit**

The induction programme should be inspected.

#### **Education 4.4 Assessors' guidance**

It may be useful to speak to the newest member of staff as well as inspecting the induction programme itself if he or she has commenced in post after 1 April 2003.

### **Education Indicator 5**

**There is a record of all practice-employed staff having attended training/updating in basic life support skills in the preceding 36 months**

#### **Education 5.1 Practice guidance**

Although it is rare for practice non-clinical staff to have to deal with a cardio-pulmonary collapse, the situation may arise within or outwith the practice premises.

See Education 1.

The interval for training is pragmatically set at three years although many practices offer training on a more frequent basis.

#### **Education 5.2 Written evidence**

Attendance at CPR training should be listed. (Grade B)

#### **Education 5.3 Assessment visit**

Staff should be questioned on the date of their last CPR training.

#### **Education 5.4 Assessors' guidance**

Confirmation that practice non-clinical staff have attended training should be obtained by checking the CPR attendance list.

### **Education Indicator 6**

**The practice conducts an annual review of patient complaints and suggestions to ascertain general learning points which are shared with the team**

#### **Education 6.1 Practice guidance**

Practices and clinicians generally find complaints stressful. It is important that the practice view complaints as a potential source for learning and for change and development.

Reports should include a summary of each complaint or suggestion and an identification of any learning points which came out of the review. It may be useful to agree at the time of each review how the learning points or areas for change will be communicated to the team; it is likely that not all team members will be

involved in every review meeting for various reasons. It will also be useful to identify an individual responsible for implementing the change and monitoring its progress.

These reports may form part of the written evidence for the indicators on significant event analysis (Education 2 and Education 7).

#### **Education 6.2 Written evidence**

Reports/minutes of team meetings where learning points have been discussed should be made, with a note of the changes made as a result. (Grade A)

#### **Education 6.3 Assessment visit**

The issue of learning from complaints should be discussed with staff and doctors.

#### **Education 6.4 Assessors' guidance**

Assessors should discuss with team members their involvement in reviews of patient complaints and suggestions and how the learning points are shared with the team.

#### **Education Indicator 7**

**The practice has undertaken a minimum of twelve significant event reviews in the past 3 years which include (if these have occurred):**

- **Any death occurring in the practice premises**
- **Two new cancer diagnoses**
- **Two deaths where terminal care has taken place at home**
- **One patient complaint**
- **One suicide**
- **One section under the Mental Health Act**

#### **Education 7.1 Practice guidance**

Detail of methodology on significant event analysis is given in Education 2.

This indicator is more prescriptive in the requirement to report on specific occurrences in the practice. Clearly if certain of these events have not occurred, eg patient suicide, then this should be stated in the evidence.

#### **Education 7.2 Written evidence**

Each review case report must consist of a short commentary setting out the relevant history, the circumstances of the episode and an analysis of the conclusions to be drawn. Evidence should be presented of any clinical and organisational changes resulting from the analysis of these cases. (Grade A)

#### **Education 7.3 Assessment visit**

The reviews should be discussed.

#### **Education 7.4 Assessors' guidance**

The practice should report on its analyses in a form consistent with either of the two methods described in Education 2.

#### **Education Indicator 8**

**All practice-employed nurses have personal learning plans which have been reviewed at annual appraisal**

### **Education 8.1 Practice guidance**

The production of a personal learning plan may be one of the outcomes of the appraisal system. The plan could record the agreement between appraiser(s) and appraisee on areas for further learning, how they will be achieved, who is responsible for organising them, within what timescale, and how progress will be reviewed. It may also include learning areas which have been identified as an organisational need but which have been agreed at the appraisal as an individual development area for the appraisee to take forward. This information should be recorded.

### **Education 8.2 Written evidence**

The staff appraisal system should be described. (Grade C)

### **Education 8.3 Assessment visit**

A discussion should be held with practice-employed nursing staff about their personal learning plans.

### **Education 8.4 Assessors' guidance**

Personal learning plans should be discussed with practice-employed nursing staff.

<b>Education Indicator 9</b>
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<b>All practice-employed non-clinical team members have an annual appraisal</b>
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### **Education 9.1 Practice guidance**

Appraisal is a constructive opportunity to review performance objectives, progress and skills and identify learning needs in a protected environment. The learning needs identified may be personal to the appraisee and/or organisational learning needs which the appraisee has agreed to fulfil. The outcome of the appraisal should be a written action plan agreed between appraiser and appraisee which could include a personal learning plan for the appraisee. In addition the opportunity could be taken to review and update the appraisee's job description.

### **Education 9.2 Written evidence**

The staff appraisal system should be described. (Grade C)

### **Education 9.3 Assessment visit**

A discussion should be held with practice-employed non-clinical staff about their experience of appraisal.

### **Education 9.4 Assessors' guidance**

It may be useful to discuss the appraisal system with the non-clinical staff themselves, the practice manager and the GPs.

## Organisational Indicators – Practice Management (D)

### Summary of Indicators

<b>D. Practice Management</b>	
<b>Management 1</b> <b>1 point</b>	Individual healthcare professionals have access to information on local procedures relating to Child Protection
<b>Management 2</b> <b>1.5 points</b>	There are clearly defined arrangements for backing up computer data, back-up verification, safe storage of back-up tapes and authorisation for loading programmes where a computer is used
<b>Management 3</b> <b>0.5 points</b>	The Hepatitis B status of all doctors and relevant practice-employed staff is recorded and immunisation recommended if required in accordance with national guidance
<b>Management 4</b> <b>1 point</b>	The arrangements for instrument sterilisation comply with national guidelines as applicable to primary care
<b>Management 5</b> <b>3 points</b>	The practice offers a range of appointment times to patients, which as a minimum should include morning and afternoon appointments five mornings and four afternoons per week, except where agreed with the PCO
<b>Management 6</b> <b>2 points</b>	Person specifications and job descriptions are produced for all advertised vacancies
<b>Management 7</b> <b>3 points</b>	The practice has systems in place to ensure regular and appropriate inspection, calibration, maintenance and replacement of equipment including: <ul style="list-style-type: none"> <li>• A defined responsible person</li> <li>• Clear recording</li> <li>• Systematic pre-planned schedules</li> <li>• Reporting of faults</li> </ul>
<b>Management 8</b> <b>1 point</b>	The practice has a policy to ensure the prevention of fraud and has defined levels of financial responsibility and accountability for staff undertaking financial transactions (accounts, payroll, drawings, payment of invoices, signing cheques, petty cash, pensions, superannuation etc.)
<b>Management 9</b> <b>3 points</b>	The practice has a protocol for the identification of carers and a mechanism for the referral of carers for social services assessment
<b>Management 10</b> <b>4 points</b>	There is a written procedures manual that includes staff employment policies including equal opportunities, bullying and harassment and sickness absence (including illegal drugs, alcohol and stress), to which staff have access

#### Management Indicator 1

**Individual healthcare professionals have access to information on local procedures relating to Child Protection**

#### Management 1.1 Practice guidance

Awareness of the existence of local Child Protection procedures is mandatory and all healthcare professionals should be able to access a copy.

#### Management 1.2 Written evidence

There should be a description of how local procedures are accessed. (Grade C)

#### Management 1.3 Assessment visit

Access to local procedures should be demonstrated.

#### Management 1.4 Assessors' guidance

The assessors should check with team members what action they would take if they had reason to suspect that a child might be being abused, including which local procedures they would refer to and how.

## Management Indicator 2

**There are clearly defined arrangements for backing up computer data, back-up verification, safe storage of back-up tapes and authorisation for loading programmes where a computer is used**

### Management 2.1 Practice guidance

The practice should have a written policy which defines who is responsible for backing up data, how it is done and how often it is done. It is good practice to keep weekly and monthly backups as well as daily backups using a rotation of back-up tapes or their equivalent. It is good practice to keep a log. Tapes should be renewed at specified intervals. Verification of backups should also be carried out at regular specified intervals, especially in paper-light or paperless practices. Tapes should be stored in a fireproof safe, with a procedure in place for back-up tapes being stored off site in order to ensure confidentiality. The policy should also define the individuals who are authorised to load new software programmes.  
<http://www.nhsia.nhs.uk/erdip/pages/docsegip/evaluation/techn>

### Management 2.2 Written evidence

There should be written policy regarding:

- backing up data and verification, including the frequency of that back-up
- storage on and off site
- authorisation to load programmes. (Grade A)

### Management 2.3 Assessment visit

The back-up and loading arrangements should be demonstrated.

### Management 2.4 Assessors' guidance

The arrangements for back-up, verification and storage procedures should be checked with the responsible staff member. It is important to ascertain that staff are aware of the procedure for authorisation for loading new software.

## Management Indicator 3

**The Hepatitis B status of all doctors and relevant practice-employed staff is recorded and immunisation recommended if required in accordance with national guidance**

### Management 3.1 Practice guidance

Useful guidance on Hepatitis B risks and immunisation is contained in the UK Health Departments' publication "Guidance for Clinical Health Care Workers: protection against infection with blood borne viruses – recommendations of the Expert Advisory Group on AIDS and the Advisory Group on Hepatitis" ([www.doh.gov.uk/pub/docs/doh/chcguidl.pdf](http://www.doh.gov.uk/pub/docs/doh/chcguidl.pdf)). The BMA supplies an interactive CD ROM "Bloodborne viruses and infection control: a guide for health care professionals". (1998) This also provides access to the Health Department's guidance mentioned above.

Under the Health and Safety at Work etc Act (1974) (HSWA), GPs are legally obliged to make sure that all employees receive appropriate training and know the procedures for working safely. They must also carry out risk assessments and these could include assessing procedures under the Control of Substances Hazardous to Health Regulations 1994 (COSHH). These regulations would cover employees who have direct contact with patients' blood, other potentially infectious bodily fluids or tissues. Immunisation of doctors and staff that have direct contact with these substances is recommended in the above regulations.

The Health Department guidance "Protecting health care workers and patients from Hepatitis B" and the 1996 addendum (see above reference to the website, Annex 1) states that all health care workers who perform exposure prone procedures (EPPs) should be immunised. They should have their response to the

vaccine checked and non-responders to vaccination should be investigated for infection in order to minimise risk to patients. This guidance also states that workers whose Hepatitis B status is unknown should be tested before carrying out EPPs.

Immunisation provides protection in up to 90% of patients vaccinated, but is not a substitute for good infection control procedures.

The BMA website provides a specimen Hepatitis B immunisation policy in the general practice staff (non-medical) specimen handbook. Advice on suitable immunisation policies can also be obtained from the Occupational Health Service, which works with reference to guidelines published in "Immunisation against Infectious Disease" (see Annex 1 in the above website).

In relation to confidentiality, the BMA Website offers the following guidance:

"It is extremely important that hepatitis B infected health care workers have the same right of confidentiality as any patient seeking or receiving medical care. Occupational health notes are separate from other hospital notes and occupational health physicians are ethically and professionally obliged not to release information without the consent of the individual. There are occasions when an employer may need to be advised that a change of duties should take place, but hepatitis B status itself will not normally be disclosed without the health care worker's consent. However, where patients are, or have been, at risk of exposure to hepatitis B from an infected healthcare worker, it may be necessary in the public interest for the employer to have access to confidential information".

#### **Management 3.2 Written evidence**

There should be evidence that the Hepatitis B status of all staff is known. (Grade C)

#### **Management 3.3 Assessment visit**

Questioning should take place on the system to check Hepatitis B status.

#### **Management 3.4 Assessors' guidance**

It should be confirmed that evidence is available that the Hepatitis B status of all doctors and relevant practice-employed staff has been recorded and that there is a mechanism for recommending (and recording any recommendation) regarding vaccination to the doctor or staff member, including checking response to vaccination.

#### **Management Indicator 4**

**The arrangements for instrument sterilisation comply with national guidelines as applicable to primary care**

#### **Management 4.1 Practice guidance**

The Health Departments in each Country will issue guidance relating to instrument sterilisation which will be agreed with the General Practitioners Committee.

#### **Management 4.2 Written evidence**

There must be a policy for instrument sterilisation.

#### **Management 4.3 Assessment visit**

The sterilisation arrangements should be inspected.

#### **Management 4.4 Assessors' guidance**

Definitive guidance is yet to be finalised with the departments of health.

**Management Indicator 5**

**The practice offers a range of appointment times to patients, which as a minimum should include morning and afternoon appointments five mornings and four afternoons per week, except where agreed by the PCO**

**Management 5.1 Practice guidance**

In practices which operate with open surgeries, this would mean that the practice should have a range of times of availability equivalent to the appointment range in the indicator. Patients should be offered a reasonable range of appointment times, which are advertised to them. The practice's appointment system should normally offer as a minimum the range of appointments described in the practice leaflet. In remote and rural areas, for example, or in some single-handed practices, the range of appointment availability described in the indicator will not be appropriate. In these circumstances, the practice should agree its availability with the PCO and this should be advertised in the practice leaflet. Evidence that this has been agreed should be made available to the assessor.

**Management 5.2 Written evidence**

The practice leaflet should be scrutinised for evidence of appointment times. (Grade A)

**Management 5.3 Assessment visit**

The practice leaflet and appointment book should be checked.

**Management 5.4 Assessors' guidance**

The advisers should check that the practice advertises in the practice leaflet a range of appointment times which corresponds to the indicator. The availability of such appointments should be confirmed by looking at a randomly selected week in the appointment book/appointment system. In practices offering a more limited range of appointment availability, the practice should provide evidence that the PCO has agreed the range on offer.

**Management Indicator 6**

**Person specifications and job descriptions are produced for all advertised vacancies**

**Management 6.1 Practice guidance**

Production of a person specification and job description at the time of identifying a vacancy not only ensures that the practice maximises its chances of employing the right person for the job, but protects the practice against the risk of being in breach of the following acts: the Sex Discrimination Act, Equal Pay Act, Disability Discrimination Act and Race Relations Act. The government is currently working on draft legislation covering discrimination on the grounds of sexual orientation, religion and age. It is also good practice not to discriminate on these grounds during the recruitment process.

Useful guidance on how to recruit without discrimination can be found on the following web sites:

- The Equal Opportunities Commission Code of Practice – Sex Discrimination at [www.eoc.org.uk](http://www.eoc.org.uk). If unsuccessful candidates for a post were to claim that they had been discriminated against on the grounds of sex, then they could take their complaint to an employment tribunal. The tribunal would take into account whether the Code of Practice was relevant to the circumstances of the case and, if so, failure by the practice to follow the code would be taken into consideration in its determination. The ACAS website also gives guidance on Equal Opportunities ([www.acas.org.uk](http://www.acas.org.uk)).
- The Disability Discrimination Act: Code of Practice for the elimination of discrimination in the field of employment against disabled persons or persons who have had a disability at [www.disability.gov.uk](http://www.disability.gov.uk) or [http://www.drc.org.uk/thelaw/new\\_codes\\_101004.asp](http://www.drc.org.uk/thelaw/new_codes_101004.asp) This Code of

Practice applies to employers with 15 or more employees. This threshold excluding small firms will be reviewed. The Code explains the Act in the form of answering frequently asked questions and clearly explains employers' obligations. It covers advertising, the selection process, terms and conditions of service and "reasonable adjustments".

- The Commission for Race Equality: Employment Code of Practice at: [www.cre.gov.uk/gdpract/employ\\_cop\\_1.html](http://www.cre.gov.uk/gdpract/employ_cop_1.html)  
The Code of Practice covers advertising, selection/shortlisting, uniforms, language and other areas.

### **Management 6.2 Written evidence**

The person specification and job description of the last person employed after 1 April 2003 should be available. (Grade B)

### **Management 6.3 Assessment visit**

The assessment should involve questioning on the person specification and job description of the last person employed after 1 April 2003.

### **Management 6.4 Assessors' guidance**

The assessors should check that the practice's approach to recruitment has included production of a person specification and job description relevant to the actual vacancy. Discussion could include the process used for drawing up the person specification eg who was involved and the opportunity for reviewing the job description. The practice could demonstrate understanding of how the production of the specification and job description demonstrates good employment practice.

### **Management Indicator 7**

**The practice has systems in place to ensure regular and appropriate inspection, calibration, maintenance and replacement of equipment including:**

- **A defined responsible person**
- **Clear recording**
- **Systematic pre-planned schedules**
- **Reporting of faults**

### **Management 7.1 Practice guidance**

The evidence for this criterion may form part of the statutory risk assessment activity which takes place under the Health and Safety at Work Regulations 1999 (Management Regulations). Comprehensive guidance on risk assessment can be found in the Health and Safety Executive's website on [www.hse.gov.uk](http://www.hse.gov.uk). The website provides a free booklet "Five steps to risk assessment".

This website also contains a free leaflet "Maintaining portable electrical equipment in offices and other low risk environments". This contains guidance on the appropriate person to inspect and maintain equipment in relation to the equipment's associated risks as well as suggested intervals between inspections and maintenance. For example, a printer may be inspected and maintained by a "competent" person with enough knowledge and training, who need not be an electrician. This is only one of several free leaflets available on the website; others may also be relevant to the individual practice's circumstances.

The schedule should clearly identify who has overall responsibility, who is the appropriate individual to inspect/maintain/calibrate each piece of equipment, the intervals between inspections and the system for reporting faults.

### **Management 7.2 Written evidence**

Details should be given of the system to ensure regular and appropriate inspection, calibration, maintenance and replacement of equipment meeting the stated criteria. (Grade B)

### **Management 7.3 Assessment visit**

A review of equipment requiring maintenance and of the log of inspection and maintenance should be undertaken.

#### **Management 7.4 Assessors' guidance**

The practice should have in place a system which includes risk assessment of equipment and a schedule of inspection, calibration and maintenance. This should include electrical equipment.

The responsible person will not always be the person actually carrying out the inspection; this should be specified in the schedule.

The intervals between inspection, calibration and maintenance will be different for various types of equipment dependent on their associated level of risk. Inspection, calibration and maintenance should be recorded.

There should be a clear system for reporting faults.

The practice should be able to provide a written record of inspection, calibration and maintenance for some randomly selected pieces of equipment. It would be useful to consider a range of equipment from small items (eg printer) up to larger items such as a steriliser or defibrillator.

#### **Management Indicator 8**

**The practice has a policy to ensure the prevention of fraud and has defined levels of financial responsibility and accountability for staff undertaking financial transactions (accounts, payroll, drawings, payment of invoices, signing cheques, petty cash, pensions, superannuation, etc.)**

#### **Management 8.1 Practice guidance**

The practice should have a policy which clearly defines the levels of financial responsibility in the practice. This will include a description of the activities which are carried out by the practice manager (eg payroll), other staff (eg petty cash) and partners (eg calculation of drawings) and will make clear the extent of responsibility. For example, the senior receptionist may be responsible for managing the petty cash on a day-to-day basis and may produce a monthly statement for the practice manager along with handing over cash for banking. The practice manager may then be responsible for checking this and for recording and banking the cash. The practice manager may have overall responsibility for ensuring the management of the petty cash.

The line of accountability for finance in the practice should also be clearly defined. For example, a particular partner may be identified as being responsible on behalf of the partnership for financial management. This responsibility may be delegated to the practice manager, who may have responsibility for day to day book-keeping, banking and other record-keeping, reconciling the bank statements and preparing regular financial statements for the finance partner. The finance partner will then be responsible to the partnership as a whole.

A fraud prevention policy may cover the following areas:

- a defined partner is responsible with the practice manager for business and finance affairs
- bank accounts are only operable with at least two signatories. The number of non-partners who are signatories should be restricted
- the same individual should where ever possible not be both payee and authorising signatory
- the practice should avoid undue reliance on one member of staff for financial and business controls
- staff are never paid in cash for work undertaken
- there is a written procedure for the removal of cash from petty cash

- all income and expenditure are recorded and reconciled with the bank statement
- purchases of equipment etc are only made with the prior approval of a partner – a level of expenditure may be agreed and set above which approval should be sought
- all transfers between accounts are properly authorised and can be substantiated
- all cheques signed should be accompanied by appropriate documentation eg invoice
- the practice should ensure where possible that one individual does not place an order, authorise the invoice and sign the cheque.

#### **Management 8.2 Written evidence**

The policy is provided. (Grade A)

#### **Management 8.3 Assessment visit**

Questioning is carried out on the steps taken to prevent fraud.

#### **Management 8.4 Assessors' guidance**

The practice's fraud prevention policy is discussed with the practice manager and the partner(s) with financial responsibility.

#### **Management Indicator 9**

**The practice has a protocol for the identification of carers and a mechanism for the referral of carers for social services assessment**

#### **Management 9.1 Practice guidance**

The practice should produce a procedure for how carers are identified and a referral protocol to social services for assessment and carers with specific needs.

#### **Management 9.2 Written evidence**

The protocol is available. (Grade A)

#### **Management 9.3 Assessment visit**

The policy is discussed.

#### **Management 9.4 Assessors' guidance**

The assessors should enquire of various team members what action they would take when they identify that a carer may benefit from social services involvement.

#### **Management Indicator 10**

**There is a written procedures manual that includes staff employment policies including equal opportunities, bullying and harassment and sickness absence (including illegal drugs, alcohol and stress), to which staff have access**

### **Management 10.1 Practice guidance**

It is good employment practice to have established written procedures, which are available to staff, so that both staff and employer are clear about the steps to be taken if a problem arises. As well as the policies mentioned, the manual could include the Disciplinary and Grievance Procedure.

Useful guidance on writing these policies can be found as follows:

- Equal Opportunities Policy: The Equal Opportunities Commission – Guidelines for Equal Opportunities Employers on [www.eoc.org.uk/EOCeng/EOCcs/Advice/guidelines.asp](http://www.eoc.org.uk/EOCeng/EOCcs/Advice/guidelines.asp). Guidance can also be found on the ACAS web site on [www.acas.org.uk](http://www.acas.org.uk). This information can also be obtained from ACAS Reader Ltd, PO Box 16, Earl Shilton, Leicester LE9 8ZZ (tel 01455 852225). The Department for Education and Skills also publishes an Equal Opportunities Ten Point Plan for Employers giving practical advice on implementing equal opportunities policies.
- Bullying and Harassment: ACAS as above.
- IHM Healthcare Management Code at [ihm.org.uk](http://ihm.org.uk).
- IHM Diversity Group recommendations for Recruitment and Selection.
- Sickness Absence: ACAS as above, including their booklet entitled “Absence and Labour Turnover”.
- BMA guidance on managing absence at [bma.org.uk](http://bma.org.uk).

### **Management 10.2 Written evidence**

Employment policies should be recorded. (Grade B). Policies should be consistent with current legislation and indicate a date when the policy has been reviewed.

### **Management 10.3 Assessment visit**

The procedures manual should be inspected.

### **Management 10.4 Assessors' guidance**

The procedures manual should contain dated copies which are made available to staff of the policies relating to their employment. It should be confirmed with employed staff that they are aware of the content of the procedures manual and its whereabouts.

## Organisational Indicators – Medicines Management (E)

### Summary of Indicators

<b>E. Medicines Management</b>	
<b>Medicines 1 2 points</b>	Details of prescribed medicines are available to the prescriber at each surgery consultation
<b>Medicines 2 2 points</b>	The practice possesses the equipment and in-date emergency drugs to treat anaphylaxis
<b>Medicines 3 2 points</b>	There is a system for checking the expiry dates of emergency drugs on at least an annual Basis
<b>Medicines 4 3 points</b>	The number of hours from requesting a prescription to availability for collection by the patient is 72 hours or less (excluding weekends and bank/local holidays)
<b>Medicines 5 7 points</b>	A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed four or more repeat medicines Standard 80%
<b>Medicines 6 4 points</b>	The practice meets the PCO prescribing adviser at least annually and agrees up to three actions related to prescribing
<b>Medicines 7 4 points</b>	Where the practice has responsibility for administering regular injectable neuroleptic medication, there is a system to identify and follow up patients who do not attend
<b>Medicines 8 6 points</b>	The number of hours from requesting a prescription to availability for collection by the patient is 48 hours or less (excluding weekends and bank/local holidays)
<b>Medicines 9 8 points</b>	A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed repeat medicines Standard 80%
<b>Medicines 10 4 points</b>	The practice meets the PCO prescribing adviser at least annually, has agreed up to three actions related to prescribing and subsequently provided evidence of change

#### Medicines Indicator 1

**Details of prescribed medicines are available to the prescriber at each surgery consultation**

#### Medicines 1.1 Practice guidance

It is important that all prescribers are aware of what prescribed medication the patient is taking.

The practice should ensure this information is available to nurses when they are consulting and prescribing as well as to doctors.

#### Medicines 1.2 Written evidence

There should be a description of where prescribed medication is recorded. (Grade C)

#### Medicines 1.3 Assessment visit

The records/computer system should be inspected.

#### Medicines 1.4 Assessors' guidance

This indicator refers to nurse prescribers as well as doctors but does not refer to home visits.

#### Medicines Indicator 2

**The practice possesses the equipment and in-date emergency drugs to treat anaphylaxis**

### **Medicines 2.1 Practice guidance**

Good Medical Practice for General Practitioners states that the excellent doctor “has up-to-date emergency equipment and drugs” and anaphylaxis is one condition that may constitute an emergency in the practice premises.

### **Medicines 2.2 Written evidence**

There is a list of equipment and drugs that the practice has available to deal with an anaphylactic emergency. (Grade C)

### **Medicines 2.3 Assessment visit**

The appropriate equipment and drugs are inspected.

### **Medicines 2.4 Assessors' guidance**

The dates of emergency drugs should be checked.

### **Medicines Indicator 3**

**There is a system for checking the expiry dates of emergency drugs on at least an annual basis**

### **Medicines 3.1 Practice guidance**

Good Medical Practice for General Practitioners states that the unacceptable GP “has drugs which are out of date” and a system is required to prevent this. The system should include all emergency drugs held in the practice premises and in the doctors' bags.

### **Medicines 3.2 Written evidence**

The system is described. (Grade C)

### **Medicines 3.3 Assessment visit**

A random sample of doctors' bags and other emergency drugs is checked.

### **Medicines 3.4 Assessors' guidance**

All drugs should be in date and the doctors should be questioned on the system for keeping them up to date.

### **Medicines Indicator 4**

**The number of hours from requesting a prescription to availability for collection by the patient is 72 hours or less (excluding weekends and bank/local holidays)**

### **Medicines 4.1 Practice guidance**

Practices should provide a reasonably fast service for their repeat prescriptions. Details of how the practice's system works should be contained in the practice leaflet. If the practice can deliver the service in 48 hours, another indicator is also achieved (Indicator Med 8).

### **Medicines 4.2 Written evidence**

The practice leaflet or policy is available. ( Grade A)

### **Medicines 4.3 Assessment visit**

The receptionists are questioned on the policy.

### **Medicines 4.4 Assessors' guidance**

The assessors should check that the system for issuing repeat prescriptions can be described by the receptionists and should observe it in action.

### **Medicines Indicator 5**

**A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed four or more repeat medicines Standard 80%.**

### **Medicines 5.1 Practice guidance**

A review of medication allows an opportunity for the clinician to assess the continuing need for medication with the patient. Additionally, the condition itself for which the medication is prescribed may require monitoring as well as the medication itself. The review may not always necessarily be a face-to-face review. It is possible to review the patient's repeat prescriptions in some circumstances without seeing the patient face to face eg by telephone review or a review of the records.

The survey will show the number of patients with four or more repeat medications and the percentage who have had a medication review in the last 15 months.

A doctor, nurse prescriber or pharmacist may conduct the review.

There is a corresponding indicator which requires that all patients on repeat medication should be reviewed.

### **Medicines 5.2 Written evidence**

A survey of medication review should be undertaken. (Grade A) This could be a computerised search and print out or a survey of fifty records of patients on four or more medications.

### **Medicines 5.3 Assessment visit**

Inspection of a sample of records of patients receiving repeat medication for four or more medications should be carried out.

### **Medicines 5.4 Assessors' guidance**

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

### **Medicines Indicator 6**

**The practice meets the PCO prescribing adviser at least annually and agrees up to three actions related to prescribing**

### **Medicines 6.1 Practice guidance**

If the PCO prescribing adviser is unable to visit within the year and there has been no contact with another PCO-recognised source of prescribing advice within the year, then the practice is exempt from this indicator. In that circumstance, the practice should provide written confirmation from the PCO prescribing adviser that he or she has been unable to visit within the relevant year.

### **Medicines 6.2 Written evidence**

Three actions agreed with the PCO prescribing adviser should be produced, or written confirmation from the PCO prescribing adviser that he or she has been unable to visit within the relevant year. (Grade A)

### **Medicines 6.3 Assessment visit**

The actions should be discussed.

### **Medicines 6.4 Assessors' guidance**

This indicator will be considered to have been met if the prescribing adviser and the practice have reached agreement on the action points.

### **Medicines Indicator 7**

**Where the practice has responsibility for administering regular injectable neuroleptic medication, there is a system to identify and follow up patients who do not attend**

### **Medicines 7.1 Practice guidance**

The consequences of patient default from this system are serious. It is therefore important that the practice's follow-up system is efficient and reliable. However, because of the relatively low number of patients in this group, a simple manual system will often be effective. If the practice has the opportunity for involving a CPN in the patient follow-up system, this can contribute significantly.

### **Medicines 7.2 Written evidence**

The system should be described. (Grade C)

### **Medicines 7.3 Assessment visit**

The assessors should question the practice team on whether they have patients on injectable neuroleptic medication and ask them to demonstrate the system for identifying and following up those who do not attend.

### **Medicines 7.4 Assessors' guidance**

If the patient receives his or her injections from a hospital team that is responsible for this care, then the practice does not need to include those patients who receive their injection in this way in their system. This for example would apply in relation to a CPN who reports to the mental health team rather than to the practice.

### **Medicines Indicator 8**

**The number of hours from requesting a prescription to availability for collection by the patient is 48 hours or less (excluding weekends and bank/local holidays)**

### **Medicines 8.1 Practice guidance**

Patients tend to prefer a reasonably fast service for their repeat prescriptions. Details of how the practice's system works should be contained in the practice leaflet. If the practice can achieve this in 72 hours, then another indicator is achieved (Medicines Indicator 4).

### **Medicines 8.2 Written evidence**

The practice leaflet or policy is available. (Grade A)

### **Medicines 8.3 Assessment visit**

The receptionists are questioned on the policy.

### **Medicines 8.4 Assessors' guidance**

The assessors should check that the system for issuing repeat prescriptions can be described by the receptionists and should observe it in action.

### **Medicines Indicator 9**

**A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed repeat medicines Standard 80%**

### **Medicines 9.1 Practice guidance**

A review of medication allows an opportunity for the clinician to assess the continuing need for a medication with the patient. Additionally, the condition itself for which the medication is prescribed may require monitoring as well as the medication itself. The review may not always necessarily be a face-to-face review. It is possible to review the patient's repeat prescriptions in some circumstances without seeing the patient face to face e.g. by telephone review or a review of the records.

Another indicator requires that medication should be reviewed for all patients being prescribed four or more repeat medications (Medicines Indicator 5).

### **Medicines 9.2 Written evidence**

A survey of medication reviews should be undertaken. (Grade A) This could be a computerised search and print out or a survey of fifty records of patients on repeat medications.

### **Medicines 9.3 Assessment visit**

Inspection of records should be carried out.

### **Medicines 9.4 Assessors' guidance**

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

### **Medicines Indicator 10**

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

### **Medicines 10.1 Practice guidance**

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

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

### **Medicines 10.2 Written evidence**

Three actions agreed with the PCO prescribing adviser and evidence of change should be produced, and/or written support from the prescribing adviser for the reasons for not achieving change, or written

confirmation from the PCO prescribing adviser that he or she has been unable to visit within the relevant year. (Grade A)

### **Medicines 10.3 Assessment visit**

Actions and improvements should be discussed.

### **Medicines 10.4 Assessors' guidance**

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

## Section 4: Patient Experience

<p><b>PE Patient Experience</b></p> <p><b>PE 1 Length of Consultations</b></p> <p>The length of routine booked appointments with the doctors in the practice is not less than 10 minutes. [If the practice routinely sees extras during booked surgeries, then the average booked consultation length should allow for the average number of extras seen in a surgery session. If the extras are seen at the end, then it is not necessary to make this adjustment.]</p> <p>For practices with only an open surgery system, the average face-to-face time spent by the GP with the patient is at least 8 minutes.</p> <p>Practices that routinely operate a mixed economy of booked and open surgeries should report on both criteria.</p>
<p><b>PE 2 Patient Surveys (1)</b></p> <p>The practice will have undertaken an approved patient survey each year.</p>
<p><b>PE 3 Patient Surveys (2)</b></p> <p>The practice will have undertaken a patient survey each year, have reflected on the results and have proposed changes if appropriate.</p>
<p><b>PE 4 Patient Surveys (3)</b></p> <p>The practice will have undertaken a patient survey each year and discussed the results as a team and with either a patient group or Non-Executive Director of the PCO. Appropriate changes will have been proposed with some evidence that the changes have been enacted.</p>

### PE 1 Length of Consultations

**The length of routine booked appointments with the doctors in the practice is not less than 10 minutes. [If the practice routinely sees extras during booked surgeries, then the average booked consultation length should allow for the average number of extras seen in a surgery session. If the extras are seen at the end, then it is not necessary to make this adjustment.]**

**For practices with only an open surgery system, the average face-to-face time spent by the GP with the patient is at least 8 minutes.**

**Practices that routinely operate a mixed economy of booked and open surgeries should report on both criteria.**

#### PE 1.1 Practice guidance

The contract includes an incentive for practices to provide longer consultations. This has been included as a proxy for many of the things which are crucial parts of general practice, yet cannot easily be measured – eg listening to patients, taking time, involving patients in decisions, explaining treatments etc, in addition to providing high quality care for the many conditions not specifically included in the quality and outcomes framework.

Practices can claim this payment if their normal booking interval is 10 minutes or more. ‘Normal’ means that three quarters or more of their appointments should be 10 minutes or longer. Deciding whether a practice meets this requirement depends on the booking system.

Practices with appointment systems

For practices where three quarters of patients are seen in booked appointments of 10 minutes or more, and surgery sessions are not normally interrupted by ‘extras’, the contract requirement is met. Extras seen at

the end of surgeries and patients seen in emergency surgeries should then not amount to more than a quarter of patients seen.

If extras are routinely seen during surgeries, this will reduce the effective length of time for consultation. For example, if a surgery session has 12 consultations booked at 10 minute intervals, but 6 extras are routinely added in, then the average time for patients will be  $120/18 = 6.7$  minutes, and these slots would not meet the 10 minute requirement. Practices will generally find it easier to decide whether they meet the 'three quarters' requirement if extras are seen at the end of routine surgeries, rather than fitted in during them.

Some practices use booking systems which contain a mixture of slots booked at different lengths within a single surgery. In these practices, the overall number of slots which are 10 minutes or more in length should be three quarters of the total.

#### Practices without appointment systems or with mixed systems

Some practices do not run an appointment system. In this case, or where some surgeries are regularly 'open', practices should measure the actual time of consultations in two sample weeks during each year. It is not necessary to do this if fewer than a quarter of patients are seen in open surgeries and the rest of the surgeries are booked at intervals of 10 minutes or more, as the 'three quarters' requirement will already be met.

For practices using computerised clinical systems, the length of consultations can be recorded automatically from the computer, providing the doctors know that it is being used for this purpose during the week. Where actual consultation length is measured, the average time with patients should be at least 7.25 minutes. This assumes that the face-to-face time has been 8 minutes in three quarters of consultations (equivalent to the face-to-face time in a 10 minute booked slot), and 5 minutes in the remainder.

#### Unusual systems

Practices organise consulting in a wide variety of different ways. This Guidance covers the majority of systems. However, if the practice believes that the spirit of the indicator is met but that the evidence it can provide is different, it should have discussions with the PCO at an early stage.

### **PE 1.2 Written evidence**

If submitting on length of consultation, a survey carried out on two separate weeks of consultation length or a computer printout which details the average consultation length should be available. (Grade A)

### **PE 1.3 Assessment visit**

If the practice operate an appointment system, inspection of the appointments book (whether paper or computerised) should be carried out, looking at a sample of days over the preceding year.

If the practice has submitted a survey of consultation length, this should be reviewed.

### **PE 1.4 Assessors' guidance**

The assessors may need to look at a number of sample days to confirm that 75% of consultations have been booked at least at 10 minute intervals.

If a manual survey of average consultation time has been submitted the assessors should question the doctors and reception staff on how and when this was carried out.

## **PE 2 Patient Surveys (1)**

**The practice will have undertaken an approved patient survey each year**

### **PE 2.1 Practice guidance**

A practice will meet the contract requirement if it has carried out a survey of patient views in the previous year, using one of two currently approved instruments (GPAQ – the General Practice Assessment

Questionnaire, and IPQ – the Improving Practice Questionnaire). Both these instruments have been widely used in the NHS and are currently being modified from their originals in order to meet the requirement of the GP contract. It is likely that other instruments will be added to the approved list following submission to and approval by the National Panel.

GPAQ is a shortened version of GPAS which has been developed for the new contract. GPAQ is available with full instructions at [www.gpas.co.uk](http://www.gpas.co.uk).

IPQ is available at <http://latis.ex.ac.uk/cfep/ipq.htm>

Practices have a choice of how to administer their survey. IPQ and GPAQ can both be administered by giving them to patients attending the surgery, and filled in after consultations with the GP. In addition, GPAQ is available in a version designed to be administered by post. In some cases, if practices consent, a PCO may take responsibility for carrying out a postal survey of all practices in its area.

One advantage of administering questionnaires in the surgery is that they can relate to an individual GP, who will then also be able to use the results in his or her revalidation folder. Surveys carried out by post do not generally relate to a named doctor, except in single-handed practices.

The aim should be to have questionnaires returned by at least 25 patients per 1000 registered patients on the practice's list. If surveys are carried out in the surgery, these should be conducted on consecutive patients. If carried out by post, adult patients should be randomly sampled, and sufficient questionnaires should be sent out to get 25 questionnaires back per 1000 registered patients back.

## **PE 2.2 Written evidence**

Practices should provide evidence that the survey has been undertaken including the date and methodology.

## **PE 3 Patient Surveys (2)**

**The practice will have undertaken a patient survey each year, have reflected on the results and have proposed changes if appropriate**

### **PE 3.1 Practice guidance**

The practice will undertake one of the surveys detailed in PE 2.

The practice should examine the results of the survey and consider whether there are areas where changes could be made to improve the services and quality of care for patients. This could take the form of a practice meeting involving members of the team.

The practice at level 2 need not provide the results of the survey but should provide an overview of its analysis of the survey and any subsequent proposals for change. Some proposals for change may have resource consequences which need to be discussed with the PCO. This could take the form of a report from a team meeting.

### **PE 3.2 Written evidence**

A report from the practice should be available.

#### **PE 4 Patient Surveys (3)**

**The practice will have undertaken a patient survey each year and discussed the results as a team and with either a patient group or Non-Executive Director of the PCO. Appropriate changes will have been proposed with some evidence that the changes have been enacted**

##### **PE 4.1 Practice guidance**

Practices should have undertaken a recommended patient survey and have discussed it as a team. (See PE 2 and PE 3.)

Subsequently the team should share its results with a Non-Executive Director of the PCO or with a patient group at a practice meeting. If the practice has a patient participation group then this group may be utilised.

If no patient group exists, one could be convened using one or more of the following methods:

- an advertisement placed in the waiting room at least two weeks before the meeting
- a random sample of patients who are written to and invited by the practice at least three weeks in advance of the meeting
- an advertisement in the practice newsletter if the practice has one
- a leaflet handed out by reception staff or a notice on the side of prescriptions.

Practices may wish to convene a focus group with particular service needs, eg mothers with young children, the elderly etc, with which to share the results of the survey.

##### **PE 4.2 Written evidence**

Practices should submit a report of the meeting which should be agreed with the Non-Executive Director or copied to patients who have attended the meeting. The report should propose changes as appropriate. In subsequent years, evidence that some change has been achieved should be provided by a report or by demonstrating a positive change in the patient survey.

## Section 5: Additional Services

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

<b>Additional</b>	<b>Cervical Screening (CS)</b>
<b>CS 1 11 points</b>	The percentage of patients aged from 25 to 64 (in Scotland from 21 to 60) whose notes record that a cervical smear has been performed in the last five years Standard 25 – 80%
<b>CS 2 3 points</b>	The practice has a system to ensure inadequate/abnormal smears are followed up
<b>CS 3 2 points</b>	The practice has a policy on how to identify and follow up cervical smear defaulters. Patients may opt for exclusion from the cervical cytology recall register by completing a written statement which is filed in the patient record (exception reporting)
<b>CS 4 2 points</b>	Women who have opted for exclusion from the cervical cytology recall register must be offered the opportunity to change their decision at least every 5 years
<b>CS 5 2 points</b>	The practice has a system for informing all women of the results of cervical smears
<b>CS 6 2 points</b>	The practice has a policy for auditing its cervical screening service, and performs an audit of inadequate cervical smears in relation to individual smear-takers at least every 2 years
<b>Additional</b>	<b>Child Health Surveillance (CHS)</b>
<b>CHS 1 6 points</b>	Child development checks are offered at the intervals agreed in local or national guidelines and problems are followed up
<b>Additional</b>	<b>Maternity Services (MAT)</b>
<b>MAT 1 6 points</b>	Ante-natal care and screening are offered according to current local guidelines
<b>Additional</b>	<b>Contraceptive Services (CON)</b>
<b>CON 1 1 point</b>	The team has a written policy for responding to requests for emergency contraception
<b>CON 2 1 point</b>	The team has a policy for providing pre-conceptual advice

## **Additional - Cervical Screening (CS)**

### **CS Indicator 1**

**The percentage of patients aged from 25 to 64 (in Scotland from 21 to 60) whose notes record that a cervical smear has been performed in the last 5 years Standard 25 – 80%**

#### **CS 1.1 Practice guidance**

This indicator reflects the previous target payment system for cervical screening and is designed to encourage and incentivise practices to continue to achieve high levels of uptake in cervical screening.

The practice should provide evidence of the number of eligible women aged from 25 to 64 (from 21 to 60 in Scotland) who have had a cervical smear performed in the last 60 months.

This indicator differs from all the other additional service indicators in that a sliding scale will apply between 25 and 80%, in a similar fashion to the clinical indicators.

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

#### **CS 1.2 Written evidence**

There should be a computer print-out showing the number of eligible women on the practice list, the number exception reported and the number who have had an a cervical smear performed in the last 5 years. (Grade A) In many areas the PCO may provide these data although, other than patients with hysterectomy, they will be unaware of exceptions, for example patients who have been invited on three occasions but failed to attend or those who have opted out of the screening programme. Practices should remove patients from the denominator in the same way as with the clinical indicators.

#### **CS 1.3 Assessment visit**

The print-out should be inspected.

#### **CS 1.4 Assessors' guidance**

The assessors should enquire on how patients who are exception-reported are identified and recorded.

### **CS Indicator 2**

**The practice has a system to ensure inadequate/abnormal smears are followed up**

#### **CS 2.1 Practice guidance**

If a good system is not in place this is an area of great risk for general practice. The system can be run outwith the practice but needs to cover inadequate and abnormal smears and the practice team need to be aware how it operates.

#### **CS 2.2 Written evidence**

The system should be described. (Grade C)

#### **CS 2.3 Assessment visit**

The system for follow up is checked.

#### **CS 2.4 Assessors' guidance**

It is important to ascertain where the responsibility for the follow-up of abnormal and inadequate smears lies. This is increasingly becoming a centralised function.

#### **CS Indicator 3**

**The practice has a policy on how to identify and follow up cervical smear defaulters. Patients may opt for exclusion from the cervical cytology recall register by completing a written statement which is filed in the patient record (exception reporting)**

#### **CS 3.1 Practice guidance**

The policy may have been drawn up outwith the practice but the members of the team need to have knowledge of the policy.

#### **CS 3.2 Written evidence**

There should be a written policy. (Grade A).

#### **CS 3.3 Assessment visit**

The policy should be discussed with relevant staff.

#### **CS 3.4 Assessors' guidance**

It may be necessary to ask the practice to demonstrate how its policy operates.

#### **CS Indicator 4**

**Women who have opted for exclusion from the cervical cytology recall register must be offered the opportunity to change their decision at least every 5 years**

#### **CS 4.1 Practice guidance**

Women who wish to opt out should not be permanently excluded from the register. Although they need not be sent a reminder letter on a regular basis, it is important that periodically women who have opted out of cytology are given the opportunity to reconsider their decision. There should be a system in place to offer cervical cytology at least every 5 years to those women who have elected to be excluded from recall for cervical cytology.

#### **CS 4.2 Written evidence**

There should be a description of how women who opt out of the cervical cytology recall register are identified and offered cervical cytology every 5 years. (Grade C)

#### **CS 4.3 Assessment visit**

The practice should demonstrate how women who opt out are identified and recalled.

#### **CS 4.4 Assessors' guidance**

The system may be run centrally but it is important to identify where the responsibility for the system lies.

**CS Indicator 5**

**The practice has a system for informing all women of the results of cervical smears**

**CS 5.1 Practice guidance**

It is generally accepted as good practice for all women who have had a cervical smear performed to be actively informed of the result. Responsibility for the system may be outwith the practice.

**CS 5.2 Written evidence**

There should be a description of system and example of letters sent to patients (Grade C)

**CS 5.3 Assessment visit**

The team should be questioned on how women are informed of the way they will obtain the result of their smear.

**CS 5.4 Assessors' guidance**

A letter sent to the patient containing and explaining the result is ideal.

**CS Indicator 6**

**The practice has a policy for auditing its cervical screening service, and performs an audit of inadequate cervical smears in relation to individual smear-takers at least every 2 years**

**CS 6.1 Practice guidance**

In this audit the criteria, the results, analysis of results, corrective action, the results of the re-audit and a discussion of them needs to be presented. The standard or level of performance against which the criterion is judged would usually involve looking for smear-takers who are obvious outliers in relation to the reading laboratory's average for inadequate smears.

**CS 6.2 Written evidence**

An audit of inadequate smears should be recorded. (Grade A)

**CS 6.3 Assessment visit**

A discussion with smear-takers should take place, dealing with the audit and any educational needs which arose and how these were met.

**CS 6.4 Assessors' guidance**

All the elements for an audit stated in the practice guidance needs to be present.

## **Additional - Child Health Surveillance (CHS)**

### **CHS Indicator 1**

**Child development checks are offered at the intervals agreed in local or national guidelines and problems are followed up**

#### **CHS 1.1 Practice guidance**

The child health surveillance programme should be based on either local or national guidelines. It is important that the practice has a system to ensure follow-up of any identified problem and that referrals are made as appropriate.

#### **CHS 1.2 Written evidence**

There should be a description of the child health surveillance programme and how problems are followed up. (Grade C)

#### **CHS 1.3 Assessment visit**

The practice team is asked for details of child health surveillance in the practice and how problems are followed up.

#### **CHS 1.4 Assessors' guidance**

The practice should be aware of which guidelines it has adopted. The assessors should be content that there is a process to ensure problems are followed up.

## **Additional - Maternity Services (MAT)**

<b>MAT Indicator 1</b>
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<b>Anti-natal care and screening are offered according to current local guidelines</b>
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### **MAT 1.1 Practice guidance**

Most local areas have produced guidelines, which should be adopted within the practice.

### **MAT 1.2 Written evidence**

There should be written guidelines on ante-natal care and screening. (Grade A)

### **MAT 1.3 Assessment visit**

The assessment should involve a description of ante-natal care, using the illustration of one case.

### **MAT 1.4 Assessors' guidance**

The case should show that the guidance is known and is being used.

## **Additional - Contraceptive Services (CON)**

<b>CON Indicator 1</b>
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<b>The team has a written policy for responding to requests for emergency contraception</b>
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### **CON 1.1 Practice guidance**

The purpose of the policy is to ensure requests for emergency contraception are appropriately handled so that it can be offered within the effective time. Receptionists as well as clinicians will need to be aware of and act on the policy.

### **CON 1.2 Written evidence**

There should be a written policy on responding to requests for emergency contraception. (Grade A)

### **CON 1.3 Assessment visit**

The policy should be discussed.

### **CON 1.4 Assessors' guidance**

The policy must allow emergency contraception to be given within the effective time.

<b>CON Indicator 2</b>
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<b>The team has a policy for providing pre-conceptual advice</b>
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### **CON 2.1 Practice guidance**

The policy should cover such areas as smoking, alcohol, diet, prophylactic folic acid, rubella status, any genetically inherited condition, substance abuse and any pre-existing medical condition.

### **CON 2.2 Written evidence**

There should be a written policy for providing pre-conceptual advice. (Grade A)

### **CON 2.3 Assessment visit**

The policy should be discussed.

### **CON 2.4 Assessors' guidance**

All the elements contained in the practice guidance (2.1) should be present in the policy.



## **COMMENTS AND FEEDBACK**

Any comments or feedback on this guidance should be emailed to GPC on

[twolf@bma.org.uk](mailto:twolf@bma.org.uk)