

* some values on pages 140 and 234 have been amended (see [PCA\(M\)\(2009\)16](#))



Dear Colleague

GENERAL MEDICAL SERVICES STATEMENT OF FINANCIAL ENTITLEMENTS FOR 2009/10

Summary

1. This Circular introduces a revised Statement of Financial Entitlements (SFE) for GMS Contractors to incorporate the changes to QOF PE7 and PE8, and childhood immunisations as a result of the UK agreement on GP delivery of the H1N1 vaccination programme. This replaces the previous SFE introduced under NHS Circular PCA(M)(2009)10 issued on 9 September 2009.
2. The SFE has been agreed with the Scottish General Practitioner's Committee and specific details to sections of the SFE are detailed at Annex A.
3. An electronic copy of the SFE can be found on the NHS website at

[http://www.sehd.scot.nhs.uk/pca/PCA2009\(M\)15.pdf](http://www.sehd.scot.nhs.uk/pca/PCA2009(M)15.pdf)

Action

- 4 NHS Boards are requested to bring this Circular to the attention of GP practices in their area and their Local Medical Committee for the attention of the Secretary of the GP sub-committee.

Yours sincerely

FRANK STRANG
Deputy Director, Primary Care Division

29 October 2009

Addresses

For action

Chief Executives NHS Boards
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Annex A

Amendments made to SFE effective from 29 October 2009

Part 2, Section 4 –Quality and Outcome Framework.

Calculation of points in the patient experience domain

(a) The wording of paragraph 4.15 has been amended from -

4.15 This domain, in Section 4 of the QOF, contains three indicators, all of which relate to patient experience: the first is about the length of patient consultations and the second and third indicators are about patient experience of access. The method of calculating the number of points earned under the indicator relating to the length of patient consultations is set out in paragraph 4.16. The method of calculating the number of points earned under the indicators relating to patient experience of access is set out in the paragraphs 4.17 to 4.18.

To

4.15 This domain, in Section 4 of the QOF, contains three indicators, all of which relate to patient experience: the first is about the length of patient consultations and the second and third indicators are about patient experience of access. The method of calculating the number of points earned under the indicator relating to the length of patient consultations is set out in paragraph 4.16. The method of calculating the number of points earned under the indicators relating to patient experience of access is set out in the paragraphs 4.17 to 4.18E. There are specific provisions in paragraph 4.18BA to 4.18BC in relation to the calculation of such points in respect of the financial year 2009/2010 for those contractors who enter into arrangements with the NHS Board to participate in the NHS Board's Pandemic Influenza (H1N1) Vaccination Scheme established in accordance with the Primary Medical Services (Directed Enhanced Service-Pandemic Influenza (H1N1) Vaccination Scheme) (Scotland) Directions 2009 which came into effect on 29 October 2009.

(b) After paragraph 4.18B the following has been inserted-

4.18BA If a contractor has on or before 31 March 2010 entered into arrangements with the NHS Board to participate in the NHS Board's Pandemic Influenza (H1N1) Vaccination Scheme established in accordance with the Primary Medical Services (Directed Enhanced Services – Pandemic Influenza (H1N1) Vaccination Scheme) (Scotland) Directions 2009 which came into effect on [date] the NHS Board must, as soon as practicable after 31 March 2010, calculate the percentage of those of the contractor's registered patients who are in the priority groups specified in Direction 4 (a) of the Primary Medical Services (Directed Enhanced Services – Pandemic Influenza (H1N1) Vaccination Scheme) (Scotland) Directions 2009 who have been vaccinated or are deemed to have been vaccinated under those arrangements by the contractor. For these purposes-

(a) a patient is vaccinated under those arrangements by the contractor if they have received the recommended doses of the H1N1 vaccine as specified in the Vaccine Schedule at paragraph 13 of the letter signed by the Chief Medical Officer, the Chief Nursing Officer and the Chief Pharmaceutical Officer dated 21 October 2009 with reference SGHD/CMO(2009)12.

(b) a patient is deemed to have been vaccinated under those arrangements by the contractor if-

(i) they are on the contractor's housebound patient list (as defined in the Primary Medical Services (Directed Enhanced Services – Pandemic Influenza (H1N1) Vaccination Scheme) (Scotland) Directions 2009 and have received the appropriate dosage even if those vaccinations were not administered by the contractor, or

(ii) they were vaccinated before the arrangement were entered into, provided the contractor was responsible for administering the vaccine, and the patient to whom the contractor would have been obliged to offer the vaccine under the arrangement subsequently entered into, had that vaccine not already been administered.

4.18BB If the percentage calculated in accordance with section 4.18BA is greater than 50.7%

the contractor's points in respect of indicators PE7 for the financial year 2009/2010 will be calculated in accordance with the provisions of this section but as though the minimum percentage threshold set out in Annex E in respect of that indicator was 50% and as though the maximum percentage threshold set out in Annex E in respect of that indicator were 80% and the contractor's points in respect of indicators PE8 for the financial year 2009/2010 will be calculated in accordance with the provisions of this section but as though the minimum percentage threshold set out in Annex E in respect of that indicator was 40% and as though the maximum percentage threshold set out in Annex E in respect of that indicator were 80%

4.18BC If the percentage so calculated is 50.7% or less or if the contractor has not on or before 31 March 2010 entered into arrangements with the NHS Board to participate in the NHS Board's Pandemic Influenza (H1N1) Vaccination Scheme established in accordance with the Primary Medical Services (Directed Enhanced Service-Pandemic Influenza (H1N1) Vaccination Scheme)(Scotland) Directions 2009, the contractor's points in respect of PE7 and PE8 for the financial year 2009/2010 will be calculated in accordance with the provisions of this Section and on the basis of the financial thresholds set out in Annex E.

(c) Paragraph 4.18C has been amended from-

4.18C If a contractor has achieved a percentage result in relation to either indicator that is the minimum set for that indicator or is below that minimum, it achieves no points in relation to that indicator. If a contractor has achieved a percentage result in relation to either indicator that is between the minimum and the maximum set for that indicator, it achieves a proportion of the points available in relation to that indicator. The proportion is calculated as follows.

To

4.18C If a contractor has achieved a percentage result in relation to either indicator that is the minimum set for that indicator or is below that minimum (subject to any adjustment

required in respect of the financial year 2009/2010 in accordance with paragraphs 4.18BA and 4.18BB) , it achieves no points in relation to that indicator. If a contractor has achieved a percentage result in relation to either indicator that is between the minimum and the maximum set for that indicator (subject to any adjustment required in respect of the financial year 2009/2010 in accordance with paragraphs 4.18BA and 4.18BB), it achieves a proportion of the points available in relation to that indicator. The proportion is calculated as follows.

Part 3, Section 8 – Childhood Immunisation Scheme

(a) In paragraph 8.10, after the words “ unless the information the Health Board needs to calculate the payment is supplied late” and immediately before the table the following wording has been added-

“Specific provision applies in respect of the calculation of TYOIP in relation to quarter 3 of the financial year 2009/2010 i.e. the quarter commencing on 1 October 2009. If the contractor has before 31st December 2009 entered into arrangements with the NHS Board to participate in the NHS Board Pandemic Influenza (H1N1) Vaccination Scheme established in accordance with the Primary Medical Services (Directed Enhanced Services-Pandemic Influenza (H1N1) Vaccination Scheme)(Scotland) Directions 2009, the final date for immunisations which count towards the payment for that quarter will be 11th February 2010 and not 31st December 2009 as would normally be required in accordance with the table below”.

(b) After paragraph 8.20, the following has been inserted-

“8.20A Specific provision applies in respect of the calculation of FYOIP in relation to quarter 3 of the financial year 2009/2010 i.e. the quarter commencing on 1 October 2009. If the contractor has before 31st December 2009 entered into arrangements with the NHS Board to participate in the NHS Board’s Pandemic Influenza (H1N1) Vaccination Scheme established in accordance with the Primary Medical Services (Directed Enhanced Service-Pandemic Influenza(H1N1)Vaccination Scheme)(Scotland) Directions 2009, the final date for immunisations which count towards the payment for that quarter will be 11th February 2010 and not 31st December 2009 as would normally be required in accordance with the table in paragraph 8.10”.

Annex A – Glossary Part 2 – Definitions

After the definition of “Non-GP provider” , the following definition is inserted-

“Pandemic Influenza (H1N1) Vaccination Scheme 2009 means the Primary Medical Services (Directed Enhanced Services- Pandemic Influenza (H1N1) Vaccination Scheme) (Scotland) 2009”.

GMS STATEMENT OF FINANCIAL ENTITLEMENTS

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1. Introduction

1.1 Scottish Ministers, in exercise of the powers conferred upon them by section 17M and 105(6) of the National Health Service (Scotland) Act 1978¹, and of all other powers enabling them in that behalf, after consulting in accordance with section 17M(4) of the 1978 Act both with the bodies appearing to them to be representative of persons to whose remuneration these directions relate and with such other persons as they think appropriate, gives the directions set out in this Statement of Financial Entitlements (“SFE”).

1.2 This SFE relates to the payments to be made by Health Boards to a contractor under a general medical services (“GMS”) contract. It replaces the Statement of Financial Entitlements, signed on 8 September 2009 and shall have effect as from 29 October 2009. Previous SFEs continue to have effect in relation to claims for payments that relate to the relevant financial years.

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

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

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

1.5 The directions given in this SFE apply to Scotland only. They were authorised to be given, and by an instrument in writing, on behalf of Scottish Ministers, by Frank Strang, a member of the Senior Civil Service, on 29 October 2009 and shall come into force with effect from 29 October 2009.

1.6 This SFE may be revised at any time, in certain circumstances with retrospective effect.² For the most up-to-date information, contact the Scottish Government Health Directorate, Directorate of Primary Care and Community Care,

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

² See section 17M(3)(e) of the NHS Act 1978

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

signed by authority of the Scottish Ministers



Frank Strang
Scottish Government Health Directorate: A member of the Senior Civil Service

PART 1

GLOBAL SUM AND MINIMUM PRACTICE INCOME GUARANTEE

2. Global Sum Payments

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

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

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

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

2.3 The Scottish Allocation Formula, a summary of which is included in Annex B of this SFE, determines how the total Global Sum amount for Scotland is to be distributed to all practices in Scotland. Once the contractor's CRP has been established, this number is to be adjusted by the Scottish Allocation Formula. The resulting figure, which is the contractor's Contractor Weighted Population for the Quarter. It is on the basis of the Contractor Weighted Population for the Quarter, relative to the Scotland-wide Weighted Population for the Quarter, that the practice is allocated its share of the Scotland-wide global sum, not including the sums allocated for Temporary Patients Adjustments. From 1 April 2009 the global sum amount for Scotland is increased to £330.0 million reflecting the increase in aggregate contractor registered populations from 1 April 2008 to 1 April 2009

Calculation of Initial Global Sum Monthly Payment for 2009/10

For 2009/10 only, the following steps will be carried out in implementing the agreed methodology for applying the recommendation of the Review Body on Doctors' and Dentists' Remuneration:

- The contractor's share produced by the calculation in paragraph 2.3 will be increased by 2.39%
- Then the annual amount of the contractor's Temporary Patients Adjustment will be added.

- Then opt-outs as described in paragraph 2.5 below will be deducted
- Then the correction factor will be adjusted by reducing it by the additional amount allocated as a result of the previous steps outlined above in this paragraph, unless this results in a negative correction factor in which case the correction factor will be taken to be zero.

Then the following steps will be carried out:

- The difference between the total increase of 2.39% and the final increase resulting from the above steps including adjustment of correction factor will be reallocated to the contractor's share produced by the calculation in paragraph 2.3
- Then the annual amount of the contractor's Temporary Patients Adjustment will be added
- Then opt-outs as described in paragraph 2.5 will be deducted.
- Then the correction factor will be adjusted by reducing it by the additional amount allocated as a result of the previous steps outlined above in this paragraph, unless this results in a negative correction factor in which case the correction factor will be taken to be zero.

The above steps will be continued to be applied until all of the original 2.39% has been allocated.

2.4 For comparative purposes only, this figure should correspond to the Contractors Weighted Population for the Quarter multiplied by approximately £69. This figure is calculated by taking the total global sum amount for Scotland (£378.1m), subtracting the total sum allocated for Temporary Patients Adjustments and then dividing by the Scotland-wide registered population for the Quarter.³ The resulting amount is then to be divided by twelve, and the resulting amount from that calculation is the contractor's first Initial GSMP for the financial year.

Calculation of Adjusted Global Sum Monthly Payments

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

- one of the Additional or Out-of-Hours Services listed in column 1 of the Table, the contractor's Adjusted GSMP will be its Initial GSMP reduced by the percentage listed opposite the service it is not going to provide in column 2 of the Table;
- more than one of the Additional or Out-of-Hours Services listed in column 1 of the Table, an amount is to be deducted in respect of each service it is not going to provide. The value of the deduction for each service is to be calculated by reducing the contractor's Initial GSMP

³ The figure of £378.1m takes effect with this SFE on 1 April 2009 and includes non-GMS practices. The equivalent figure prior to 1 April 2009 was £328.3m. The new figure reflects the implementation of the DDRB 2009 recommendations and the change in Scotland's registered populations for the period 01 April 2008 to 31 March 2009

by the percentage listed opposite that service in column 2 of the Table, without any other deductions from the Initial GSMP first being taken into account. The total of all the deductions in respect of each service is then deducted from Initial GSMP to produce the Adjusted GSMP.

TABLE

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

First Payable Global Sum Monthly Payment

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

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

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

Revision of Payable Global Sum Monthly Payments

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

- (a) at the start of each quarter ;

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

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

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

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

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

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

- (b) the appropriate proportion of its new Payable GSMP. This is to be calculated by multiplying its new Payable GSMP by the fraction produced by dividing–
 - (i) the number of days left in the month after the change to which the new Payable GSMP relates takes effect, by
 - (ii) the total number of days in the month.

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

Conditions attached to Payable Global Sum Monthly Payments

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

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

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

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

- (a) 150; by

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

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

Contractor Population Index

2.18 The Contractor Population Index (CPI) of a contractor, mentioned in paragraph 2.16, is the contractor's most recently established CRP divided by 5150.⁴ Where reference is made in this SFE to a contractor's CPI, that reference, unless the context otherwise requires, is to the most up-to-date version of the contractor's CPI at the time that the payment which is being adjusted in accordance with a calculation using the contractor's CPI falls due.

⁴ The figure of 5150 takes effect with this SFE from 01 April 2009. The equivalent figure prior to 01 April 2009 was 5124. The new figure reflects the notional change in the Scotland's registered population for the period 01 April 2008 and 31 March 2009.

3. Minimum Practice Income Guarantee

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

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

Calculation of Global Sum Equivalent

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

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

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

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

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

The resulting amount was the contractor's Final GSE.

Calculation of Correction Factor Monthly Payments

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

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

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

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

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

first being taken into account. The total of all the amounts in respect of each service was then aggregated to produce the final amount of the contractor's Historic Opt-Outs Adjustment.

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

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

Continuing obligation to pay Correction Factor Monthly Payments

Review and revision of Correction Factor Monthly Payments in respect of financial years 2009/10, 20010/11 and financial years thereafter.

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

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

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

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

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

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

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

(a) for the financial year 2009 to 2010 by 0.68% of the practices' GSE, This calculation is made in order to implement the DDRB recommendation for 2009/10 and ensure that all practices receive a minimum uplift in their GSE according to the methodology which was jointly agreed. Because GSE is the combined total of the practice's Global Sum and Correction Factor, the uplift will be applied to the Correction Factor element which will result in the creation of new temporary Correction Factors for those practices which have no existing Correction Factor; and

(b) for the financial year 2010 to 2011, and for subsequent financial years, by-

(i) the percentage by which the amount specified in paragraph 2.3 is uprated at or for the start of the new financial year ("the Uprating Percentage"), if it is to be uprated, or

(ii) if the first amount specified in paragraph 2.3 is not to be uprated at or for the start of the new financial year, by 0%",

3.13 So, if the amount specified in paragraph 2.3 is uprated at or for the start of the new financial year, the amount of the contractor's CFMPs for the new financial year is to be its baseline amount, as increased by the Uprating Percentage; otherwise, the amount of a contractor's CFMPs for the new financial year is to be its baseline amount⁵ CFMPs are to fall due on the last day of each month

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

Practice mergers or splits

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

3.16 If-

(a) a new contractor comes into existence as the result of a merger between one or more other contractors; and

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

- (b) that merger led to the termination of GMS contracts and the agreement of a new GMS contract,

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

3.17 If–

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

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

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

3.19 If–

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

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

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

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

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

Conditions attached to payment of Correction Factor Monthly Payments

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

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

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

PART 2

QUALITY AND OUTCOMES FRAMEWORK

4. Quality and Outcomes Framework: General

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

Types of payments in relation to the QOF

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

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

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

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

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

The four principal domains of the QOF

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

Calculation of points in the clinical domain

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

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

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

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

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

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

- (a) the number of patients registered with the contractor in respect of whom the task has been performed or outcome achieved (A); by

- (b) the number produced by subtracting from the total number of patients registered with the contractor with the relevant medical condition (B) the number of patients to be excluded from the calculation on the basis of the provisions in the QOF on exception reporting (C).

The provisions on exception reporting are set out in Section 2.2 of the QOF. This fraction is then multiplied by 100 for the percentage score. The calculation can be expressed as: $\frac{A}{(B - C)} \times 100 = D$.

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

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

Calculation of points in the organisational domain

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

4.14 The standards set relate either to a task to be performed or an outcome to be achieved. The points available in relation to these indicators are only obtainable (and then in full) if the task is in fact accomplished or the outcome achieved. Guidance on what is required to accomplish the task or achieve the outcome is given in Section 3 of the QOF.

Calculation of points in the patient experience domain

4.15 This domain, in Section 4 of the QOF, contains three indicators, all of which relate to patient experience: the first is about the length of patient consultations and the second and third indicators are about patient experience of access. The method of calculating the number of points earned under the indicator relating to the length of patient consultations is set out in paragraph 4.16. The method of calculating the number of points earned under the indicators relating to patient experience of access is set out in the paragraphs 4.17 to 4.18E. There are specific provisions in paragraph 4.18BA to 4.18BC in relation to the calculation of such points in respect of the financial year 2009/2010 for those contractors who enter into arrangements with the NHS Board to participate in the NHS Board's Pandemic Influenza (H1N1) Vaccination Scheme established in accordance with the Primary Medical

Services(Directed Enhanced Service-Pandemic Influenza(H1N1) Vaccination Scheme)(Scotland) Directions 2009 which came into effect on 29 October 2009.

4.16 The points available in relation to the first indicator (length of consultation) will only be obtainable (and then in full) if the relevant outcomes recorded in that indicator are achieved.

4.17 The two indicators relating to patient experience of access have designated Achievement Thresholds. The contractor's performance against the standards set out in these indicators is assessed on the basis of the percentage of patients who, in the national patient experience survey carried out during the relevant financial year indicate in respect of that contractor that they were able to obtain a consultation or book an appointment in accordance with the time limits required by the standards set out in the indicators.

4.18 If the contractor does not participate in the national patient experience survey during the financial year the contractor is not entitled to any points in respect of those indicators. If the national patient experience survey in respect of that financial year does not generate results for the contractor in respect of either indicator, the contractor is not entitled to any points in respect of that indicator.

4.18A The percentage result for the financial year (or for part of the financial year in the case of contracts that terminate prior to the end of the financial year) will be calculated using the survey results from the national patient survey that is to be used in accordance with the provisions of this Section The following example is given by way of illustration, in respect of indicator PE7, of how the survey results would be aggregated to give the final percentage result against which the contractor's performance is assessed

The percentage result is expressed as $Y/Z=X$

Where X is the percentage of patients who, in the relevant national patient survey, indicate that they were able to obtain a consultation with an appropriate health professional within 2 working days (this being the relevant indicator);

Y is the total number of survey respondents in the national patient survey that is to be used in accordance with the provisions of this Section who report contacting their GP surgery within the previous 12 months requesting to be able to obtain a consultation with an appropriate health professional within two working days; and

Z is the total number of survey respondents in the national patient survey that is to be used in accordance with the provisions of this Section who report contacting their GP surgery within the previous 12 months and requesting to obtain a consultation with a GP within two working days.

4.18B Two percentages are set in relation to each standard in these indicators-

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

4.18BA If a contractor has on or before 31 March 2010 entered into arrangements with the NHS Board to participate in the NHS Board's Pandemic Influenza (H1N1) Vaccination Scheme established in accordance with the Primary Medical Services (Directed Enhanced Services – Pandemic Influenza (H1N1) Vaccination Scheme) (Scotland) Directions 2009 which came into effect on 29 October 2009 the NHS Board must, as soon as practicable after 31 March 2010, calculate the percentage of those of the contractor's registered patients who are in the priority groups specified in Direction 4 (a) of the Primary Medical Services (Directed Enhanced Services – Pandemic Influenza (H1N1) Vaccination Scheme) (Scotland) Directions 2009 who have been vaccinated or are deemed to have been vaccinated under those arrangements by the contractor. For these purposes-

(a) a patient is vaccinated under those arrangements by the contractor if they have received the recommended doses of the H1N1 vaccine as specified in the Vaccine Schedule at paragraph 13 of the letter signed by the Chief Medical Officer, the Chief Nursing Officer and the Chief Pharmaceutical Officer dated 21 October 2009 with reference SGHD/CMO(2009)12

(b) a patient is deemed to have been vaccinated under those arrangements by the contractor if-

(i) they are on the contractor's housebound patient list (as defined in the Primary Medical Services (Directed Enhanced Services – Pandemic Influenza (H1N1) Vaccination Scheme) (Scotland) Directions 2009 and have received the appropriate dosage even if those vaccinations were not administered by the contractor, or

(ii) they were vaccinated before the arrangement were entered into, provided the contractor was responsible for administering the vaccine, and the patient to whom the contractor would have been obliged to offer the vaccine under the arrangement subsequently entered into, had that vaccine not already been administered.

4.18BB If the percentage calculated in accordance with section 4.18BA is greater than 50.7%

the contractor's points in respect of indicators PE7 for the financial year 2009/2010 will be calculated in accordance with the provisions of this section but as though the minimum percentage threshold set out in Annex E in respect of that indicator was 50% and as though the maximum percentage threshold set out in Annex E in respect of that indicator were 80% and the contractor's points in respect of indicators PE8 for the financial year 2009/2010 will be calculated in accordance with the provisions of this section but as though the minimum percentage threshold set out in Annex E in

respect of that indicator was 40% and as though the maximum percentage threshold set out in Annex E in respect of that indicator were 80%

4.18BC If the percentage so calculated is 50.7% or less or if the contractor has not on or before 31 March 2010 entered into arrangements with the NHS Board to participate in the NHS Board's Pandemic Influenza (H1N1) Vaccination Scheme established in accordance with the Primary Medical Services (Directed Enhanced Service-Pandemic Influenza (H1N1) Vaccination Scheme)(Scotland) Directions 2009, the contractor's points in respect of PE7 and PE8 for the financial year 2009/2010 will be calculated in accordance with the provisions of this Section and on the basis of the financial thresholds set out in Annex E.

4.18C If a contractor has achieved a percentage result in relation to either indicator that is the minimum set for that indicator or is below that minimum (subject to any adjustment required in respect of the financial year 2009/2010 in accordance with paragraphs 4.18BA and 4.18BB) , it achieves no points in relation to that indicator. If a contractor has achieved a percentage result in relation to either indicator that is between the minimum and the maximum set for that indicator (subject to any adjustment required in respect of the financial year 2009/2010 in accordance with paragraphs 4.18BA and 4.18BB), it achieves a proportion of the points available in relation to that indicator. The proportion is calculated as follows.

4.18D Once the Health Board has been informed of the result the contractor has actually achieved in respect of these indicators, it will need to do two calculations, one for each indicator. From the percentage achieved (A), subtract the minimum percentage score set for that indicator (B), then divide the result by the difference between the maximum (C) and minimum (B) percentage scores set for that indicator, and multiply the result of that calculation by the total number of points available in relation to that indicator (D). This can be expressed as:

$$\frac{(A - B)}{(C - B)} \times D$$

4.18E The result is the number of points to which the contractor is entitled in relation to that indicator;

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

Calculation of points in the additional services domain

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

4.21 The child health surveillance and maternity medical services indicators require particular services to be offered – and the points available in relation to these

indicators will only be obtainable (and then in full) if the service is offered to the relevant target population.

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

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

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

5. Aspiration Payments

Calculation of Monthly Aspiration Payments: general

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

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

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

Calculation of Monthly Aspiration Payments: the 70% method

5.3 If–

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

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

5.4 To calculate a contractor's Monthly Aspiration Payments by the 70% method, the contractor's Unadjusted Achievement Payment for the previous year needs to be established that is, the total established under paragraph 5.39 of the 2004/5 SFE or

paragraph 6.7 of this SFE. Generally, this will not be possible in the first quarter of the financial year, and so a Provisional Achievement Payment will need to be established by the Health Board. The amount of this payment is to be based on the contractor's return submitted in accordance with paragraph 5.35 of the 2004/5 SFE or paragraph 6.3 of this SFE. This amount will not include any element attributable to any entitlement in respect of the patient experience of access indicators in the patient experience domain.

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

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

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

and rounding the resulting figure to fifteen decimal places.

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

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

5.9 If the Provisional Achievement Payment is higher than the Unadjusted Achievement Payment calculated for the contractor, the difference between the two is to be divided by the number of complete months left in the financial year after the

actual Achievement Payment is paid. The amount produced by that calculation is to be deducted from each of the contractor's Monthly Aspiration Payments in respect of those complete months, thus producing the revised amount of that contractor's Monthly Aspiration Payments for the rest of the financial year.

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

Calculation of Monthly Aspiration Payments: the Aspiration Points Total method

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

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

5.13 If the Health Board and the contractor have agreed an Aspiration Points Total for the contractor, that total is to be divided by three. The resulting figure is to be multiplied by £126.76, and then by the contractor's CPI, which produces the annual amount of the contractor's Aspiration Payment. This is then to be divided by twelve for what, subject to paragraph 6.10, is to be the contractor's Monthly Aspiration Payment, as calculated by the Aspiration Points Total method.

Payment arrangements for Monthly Aspiration Payments

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

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

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

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

Conditions attached to Monthly Aspiration Payments

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

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



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

5.19 The additional payment for the period 1 April 2008 to 31 December 2008 which is due as a result of the change in the calculation of the monthly aspiration payment from the 60% method to the 70% method, as set out in section 5.3, will be paid with the monthly aspiration payment in January 2009

6. Achievement Payments

Basis of Achievement Payments

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

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

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

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

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

Returns in respect of Achievement Payments

6.3 In order to make a claim for an Achievement Payment, a contractor must make a return in respect of the information required of it by the Health Board in order for the Health Board to calculate its Achievement Payment. This information will not include any information relating to the contractor's performance in respect of the patient experience of access indicators in the patient experience domain as that information will not be held by the contractor. Where a GMS contract terminates

before the end of the financial year, a contractor may make a return at that stage in respect of the information necessary to calculate the Achievement Payment to which it is entitled in respect of that financial year.

6.4 On the basis of that return and (where the Health Board has such information) of the GP Access Survey results relating to that contractor as communicated to the Health Board, but subject to any revision of the Achievement Points totals that the Health Board may reasonably see fit to make–

- (a) to correct the accuracy of any points total;
- (b) where the GP Access Survey results are not available at the time the Achievement Payment is initially calculated, to take account of any Achievement Points that have been earned in respect of the patient experience of access indicators in the patient experience domain in respect of that financial year; or
- (c) having regard to any guidance issued by SGHD,

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

Calculation of Achievement Payments

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

- (a) the clinical domain (other than the area relating to palliative care), first a calculation needs to be made of an Adjusted Practice Disease factor for each disease area. (In the case of a GMS contract that only has effect for part of a financial year, there are specific provisions, set out in more detail in Annex F, as to the Adjusted Practice Disease Factor that is to be taken into account in calculating the contractor's Achievement Payment.) This is then multiplied by £126.76 and by the contractor's Achievement Points total in respect of the disease area to produce a cash amount for that disease area. Then the cash totals in respect of all the individual disease areas in the domain are to be added together to give the cash total in respect of the domain. A fuller explanation of the calculation of Adjusted Practice Disease Factors, and of the provisions that apply in the case of a GMS contract that only has effect for part of a financial year, is given in Annex G; and
- (b) the additional services domain, the Achievement Points Total in respect of each additional service is to be assessed in accordance with the guidance in Annex F, and a calculation is thereafter to be made of the cash total in respect of the domain in the manner set out in that guidance.

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

6.6 As regards all the other Achievement Points gained by the contractor, the total number of them is to be multiplied by £126.76.⁶

6.7 The cash totals produced under paragraphs 6.5 and 6.6 are then added together and multiplied by the contractor's CPI, calculated in accordance with the provisions of paragraph 2.18⁷ –

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

6.8 If the contractor's GMS contract had effect –

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

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

Recovery where Aspiration Payments have been too high

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

⁶ The amount specified in paragraph 6.6 in respect of the financial year 2008 to 2009 was £124.64

- (a) to the extent that it is possible to do so, the paragraph 6.9 amount is to be recovered by deducting one twelfth of that amount from each of the contractor's Monthly Aspiration Payments for the financial year after the financial year to which the paragraph 6.9 amount relates. In these circumstances –
 - (i) the gross amount of its Monthly Aspiration Payments for accounting and superannuation purposes in the financial year after the financial year to which the paragraph 6.9 amount relates is to be the amount to which the contractor is otherwise entitled under paragraphs 5.7 to 5.10 or paragraph 5.13, and
 - (ii) the paragraph 6.9 amount is to be treated for accounting and superannuation purposes as an overpayment in respect of the contractor's Monthly Aspiration Payments for the financial year to which the paragraph 6.9 amount relates; or
 - (b) if it is not possible to recover all or part of the paragraph 6.9 amount by the method described in sub-paragraph (a) (for example, because of the termination of the GMS contract after a partnership split), the amount that cannot be so recovered is to be treated as an overpayment in respect of the contractor's Monthly Aspiration Payments for the year to which the paragraph 6.9 amount relates, and is to be recovered accordingly (i.e. in accordance with paragraph 21.1).
- 6.11 Where the resulting amount from the calculation under paragraph 5.40 of the 2004/5 SFE is a negative amount, that negative amount, expressed as a positive amount ("the paragraph 5.40 amount"), is to be treated as an overpayment in respect of the contractor's Payable GSMPs for the financial year 2005 to 2006, and is to be recovered accordingly (i.e. in accordance with paragraph 21.1).

Accounting arrangements and due date for Achievement Payments

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

- (a) where the GMS contract terminates before the end of the financial year into which the relevant date falls, at the end of the quarter after the quarter during which the GMS contract was terminated, and
- (b) in all other cases, at the end of the first quarter of the financial year after the financial year into which the relevant date falls.

Conditions attached to Achievement Payments

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

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

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

PART 3

DIRECTED ENHANCED SERVICES

7. NOT ALLOTTED

8. Childhood Immunisations Scheme

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

Childhood Immunisations Scheme plans

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

Target payments in respect of two-year-olds

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

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

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

Calculation of Quarterly Two-Year-Olds Immunisation Payment

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

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

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

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

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

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

- (a) the Contractor;
- (b) another GMS contractor as part of primary medical services to a patient who was at that time registered with that contractor (where the term “GMS contractor” includes a contractor providing services under section 28Q of the 1977 Act, a contractor providing services under section 17J of the National Health Services (Scotland) Act 1978 or a contractor providing services under Article 57 of the Health and Personal Social Services (Northern Ireland) Order 1972);
- (c) a PMS contractor as part of primary medical services to a patient who was at that time registered with that contractor (where the term “PMS Contractor ” includes a contractor providing services under section 28C of the 1977 Act, a contractor providing services under section 17C of the National Health Services (Scotland) Act 1978 and a contractor providing services under Article 15B of the Health and Personal Social Services (Northern Ireland) Order 1972);
- (d) an Alternative Provider Medical Services contractor (“APMS contractor”) as part of primary medical services to a patient who was at that time registered with that contractor (where the term “APMS contractor” includes a contractor providing services under arrangements made under section 16CC(2)(b) of the 1977 Act, a contractor providing services under arrangements made under section 2C(2) of the National Health Services (Scotland) Act 1978 and a contractor providing services under arrangements made under Article 56(2)(b) of the Health and Personal Social Services (Northern Ireland) Order 1972); or
- (e) a Primary Care Trust Medical Services practice (“PCTMS practice”) as part of primary medical services to a patient who was at that time registered with that practice (where the term “a PCTMS practice” includes a practice providing services under arrangements made under section 16CC(2)(a) of the 1977 Act and a practice providing services under arrangements made under Article 56(2)(a) of the Health and Personal Social Services (Northern Ireland) Order 1972 (such arrangements in Northern Ireland being referred to as Health and Social Services Board Medical Services)),

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

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

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

For these purposes—

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

8.8 The maximum amounts payable to a contractor will depend on the number of children aged two whom it is under a contractual obligation to include in its Childhood Immunisations Scheme Register on the first day of each quarter compared with the average UK number of such children per 5000 population, which is 59. The maximum amounts payable to the contractor (**F**) are therefore to be calculated as follows—

- (a) where the 70% target is achieved: $(\text{F}^1) = \frac{\text{A}}{59} \times \text{£}719.37$; or
- (b) where the 90% target is achieved: $(\text{F}^2) = \frac{\text{A}}{59} \times \text{£}2,158.12$

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

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

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

Specific provision applies in respect of the calculation of TYOIP in relation to quarter 3 of the financial year 2009/2010 i.e. the quarter commencing on 1 October 2009. If the contractor has before 31st December 2009 entered into arrangements with the NHS Board to participate in the NHS Board Pandemic Influenza (H1N1) Vaccination Scheme established in accordance with the Primary Medical Services (Directed Enhanced Services-Pandemic Influenza (H1N1) Vaccination Scheme)(Scotland) Directions 2009, the final date for immunisations which count towards the payment for that quarter will be 11th February 2010 and not 31st December 2009 as would normally be required in accordance with the table below.

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

Conditions attached to Quarterly Two-Year-Olds Immunisation Payments

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

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

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

Target payments in respect of five-year-olds

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

- (a) as part of its GMS contract the contractor and the Health Board have agreed a Childhood Immunisation Scheme plan; and
- (b) as regards the cohort of children established on that day, who are registered with the contractor and who are aged five (i.e. who have passed their fifth birthday but not yet their sixth), by the end of that

quarter at least 70%, for the lower payment, or at least 90%, for the higher payment, have received all the recommended reinforcing doses (ie those that have been recommended nationally and by the World Health Organisation for protection against diphtheria, tetanus, pertussis and poliomyelitis).

Calculation of Quarterly Five-Year-Olds Immunisation Payment

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

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

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

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

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

(a) the Contractor;

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

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

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

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

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

8.18 The maximum amounts payable to a contractor will depend on the number of children aged five whom it is under a contractual obligation to include in its Childhood Immunisations Scheme Register on the first day of each quarter compared with the average UK number of such children per 5000 population, which is 54. The maximum amounts payable to the contractor (E) are therefore to be calculated as follows—

- (a) where the 70% target is achieved: $E^1 = \frac{A}{54} \times £222.82$; or
- (b) where the 90% target is achieved: $E^2 = \frac{A}{54} \times £668.47$

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

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

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

8.20A Specific provision applies in respect of the calculation of FYOIP in relation to quarter 3 of the financial year 2009/2010 i.e. the quarter commencing on 1 October 2009. If the contractor has before 31st December 2009 entered into arrangements with the NHS Board to participate in the NHS Board's Pandemic Influenza (H1N1) Vaccination Scheme established in accordance with the Primary Medical Services (Directed Enhanced Service-Pandemic Influenza(H1N1)Vaccination Scheme)(Scotland) Directions 2009, the final date for immunisations which count towards the payment for that quarter will be 11th February 2010 and not 31st December 2009 as would normally be required in accordance with the table in paragraph 8.10

Conditions attached to Quarterly Five-Year-Olds Immunisation Payments

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

- (a) the contractor must meet its obligations under its Childhood Immunisation Scheme plan;
- (b) the contractor must supply to the Health Board with sufficient information to enable the Health Board to calculate the contractor's Quarterly FYOIP. In particular, the contractor must supply the following figures–
 - (i) the number of five-year-olds whom it is under a contractual obligation to include in its Childhood Immunisations Scheme Register on the first day of each quarter in respect of which a payment is claimed,

- (ii) how many of those five-year-olds have received the complete course of recommended reinforcing doses (ie that have been recommended nationally and by the World Health Organisation) for protection against diphtheria, tetanus, pertussis and poliomyelitis by the end of the quarter in respect of which a payment is claimed, and
 - (iii) of those completed courses, how many were carried out by a contractor or practice of a type specified in, and under the circumstances specified in, any of the paragraphs 8.16 (a) to (e); and
- (c) all information supplied pursuant to or in accordance with this paragraph must be accurate.

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

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

PART 4

PAYMENTS FOR SPECIFIC PURPOSES

8A. Pneumococcal Vaccination and Hib/MenC Booster Vaccination

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

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

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

8A.4 Payments in respect of the administration by a contractor, who is contracted to provide the childhood immunisations and pre-school booster Additional Service, of the pneumococcal conjugate vaccine (PCV) as part of the catch-up programme for children who were aged over two months but under 2 years on 4th September 2006 and who, because they had already started their routine immunisation programme, cannot receive the three pneumococcal vaccinations in accordance with the table set out in paragraph 8A.8, are dealt with separately in Section 8B.

8A.5 References in this Section to the age of a child expressed in months are references to calendar months. Where reference is made to a vaccination being administered at or around a certain age, this is an indication of the recommended schedule for administration of the vaccine contained in the provisions as set out in Annex I to this SFE. The specific timing of the administration of the vaccination, which should be within the parameters of the recommended schedule, is a matter for the clinical judgement of the relevant health care professional.

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

8A.6 The Health Board must pay to a contractor who qualifies for the payment, a payment of £15.02 in respect of each child registered with the contractor—

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

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

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

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

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

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

8A.9 The Health Board must pay to a contractor who qualifies for the payment, a payment of £15.02 in respect of each child registered with the contractor who has received the PCV vaccination in any of the circumstances set out in paragraphs 8A.11 to 8A.15 and in respect of whom the contractor administered the final completing vaccination, but only where the equivalent PCV vaccinations cannot be administered as part of the pneumococcal catch-up campaign under Section 8B. If the equivalent PCV vaccination can be administered as part of the pneumococcal catch-up campaign the contractor is not entitled to any payment under this Section.

Children at increased risk of pneumococcal infection

8A.10 The table below sets out what are, for the purposes of this Section, the specific pneumococcal clinical risk groups for children.

Clinical risk group	Examples (decision based on clinical judgement)
Asplenia or dysfunction of the spleen	This includes conditions such as homozygous sickle cell disease and coeliac syndrome that may lead to splenic dysfunction.
Chronic respiratory disease	This includes chronic obstructive pulmonary disease (COPD), including chronic bronchitis and emphysema; and such conditions as bronchiectasis, cystic fibrosis, interstitial lung fibrosis, pneumoconiosis and bronchopulmonary dysplasia (BPD). Children with respiratory conditions caused by aspiration, or a neuromuscular disease (e.g. cerebral palsy) with a risk of aspiration. Asthma is not an indication, unless continuous or frequently repeated use of systemic steroids (as defined in Immunosuppression below) is needed.
Chronic heart disease	This includes those requiring regular medication and/or follow-up for ischaemic heart disease, congenital heart disease, hypertension with cardiac complications, and chronic heart failure.
Chronic renal disease	This includes nephrotic syndrome, chronic renal failure, renal transplantation.
Chronic liver disease	This includes cirrhosis, biliary atresia, chronic hepatitis
Diabetes (requiring insulin or oral hypoglycaemic drugs)	This includes type I diabetes requiring insulin or type 2 diabetes requiring oral hypoglycaemic drugs. It does not include diabetes that is diet controlled.
Immunosuppression	Due to disease or treatment, including asplenia or splenic dysfunction and HIV infection at all stages. Patients undergoing chemotherapy leading to immunosuppression. Individuals treated with or likely to be treated with systemic steroids for more than a month at a dose equivalent to prednisolone 20mg or more per day (any age), or for children under 20kg, a dose of $\geq 1\text{mg/kg/day}$. Some immunocompromised patients may have a suboptimal immunological response to the



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	vaccine.
Individuals with cochlear implants	It is important that immunisation does not delay the cochlear implantation. Where possible, pneumococcal vaccination should be completed at least 2 weeks prior to surgery to allow a protective immune response to develop. In some cases it will not be possible to complete the course prior to surgery. In this instance, the course should be started at any time prior to or following surgery and completed according to the immunisation schedule.
Individuals with Cerebrospinal fluid leaks	This includes leakage of cerebrospinal fluid such as following trauma or major skull surgery.

8A.11 Where a child who is in any of the pneumococcal clinical risk groups set out in the table in paragraph 8A.10 presents late for vaccination (that is, not in accordance with the routine schedule set out in paragraph 8A.8), and -

(a) consequently cannot receive, and has not received, the four vaccinations referred to in paragraph 8A.6(a) in accordance with the routine schedule set out in the table in paragraph 8A.8; but

(b) who nevertheless still presents in time to enable him to receive, and did receive, two doses of PCV before the age of 12 months, the Hib/Men C booster at around the age of 12 months and a third dose of PCV at around the age of 13 months,

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

8A.12 Where a child over the age of 12 months but under the age of 5 years and who is in any of the clinical risk groups set out in the table in paragraph 8A.10 presents late for vaccination (that is, not in accordance with the routine schedule set out in paragraph 8A.8), and—

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

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

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

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

8A.13 Where a child who is over 13 months but under 5 years and who has previously had invasive pneumococcal disease receives a single dose of PCV in accordance with the recommendation contained in paragraph 6 of Annex 1 of the provisions set out at Annex I to this SFE, the Health Board must pay to the contractor administering the final completing vaccination a payment of £15.02 in respect of that child, unless a payment is otherwise payable for that same final completing vaccination under paragraph 8A.12, 8A.15 or Section 8B. The single dose of PCV is considered the final completing vaccination for this purpose.

Children with an unknown or incomplete vaccination status

8A.14 Where a child who has an unknown or incomplete vaccination status receives vaccinations sufficient to ensure that he has received two doses of PCV before the age of 12 months, the Hib/MenC booster at around the age of 12 months and a third dose of PCV at around the age of 13 months, the Health Board must pay to the contractor administering the final completing vaccination a payment of £15.02 in respect of that child. The third dose of PCV is considered the final completing vaccination for this purpose.

8A.15 Where a child who has an unknown or incomplete vaccination status and is too old to be able to receive two doses of PCV before the age of 12 months, the Hib/MenC booster at around the age of 12 months and a third dose at around the age of 13 months, receives a single dose of PCV prior to the age of 24 months, the Health Board must pay to the contractor who administers the final completing vaccination a payment of £15.02 in respect of that child. The single dose of PCV is considered the final completing vaccination for this purpose

Eligibility for payment

8A.16 A contractor is only eligible for a payment under this Section in circumstances where the following conditions are met–

(a) the contractor is contracted to provide the childhood immunisation and pre-school booster Additional Service;

- (b) the child in respect of whom the payment is claimed was on the contractor's list of registered patients at the time the final completing vaccination was administered;
- (c) the contractor administers the final completing vaccination to the child in respect of whom the payment is claimed;
- (d) subject to sub-paragraph (e), the child in respect of whom the payment is claimed is aged around 13 months when the final completing vaccination is administered;
- (e) in the case of payments in respect of vaccinations administered in accordance with paragraphs 8A.12 or 8A.13, the child must be under 5 years when the final completing vaccination is administered and in the case of vaccinations administered in accordance with paragraph 8A.15, the child must be under 2 years when the final completing vaccination is administered;
- (f) the contractor does not receive any payment from any other source in respect of any of the series of three PCV vaccinations and the Hib/MenC booster vaccination set out in the table at paragraph 8A.8 or in respect of any vaccination administered under any of the circumstances set out in paragraphs 8A.11 to 8A.15 of this Section (if he does receive any such payment in respect of any child from any other source, the Health Board must give serious consideration to recovering any payment made under this Section in respect of that child pursuant to paragraph 21.1(a)); and
- (g) the contractor submits the claim within 6 months of administering the final completing vaccination.

8A.17 The Health Board may set aside the requirement that the contractor submit the claim within 6 months of administering the final completing vaccination if it considers it reasonable to do so.

8A.18 The contractor is not entitled to—

- (a) payment of more than £15.02 in respect of any child under this Section, other than where—
 - (i) the contractor claims for payment for a final completing vaccination administered under the circumstances set out in paragraph 8A.13, and
 - (ii) by virtue of that paragraph, the contractor is entitled to a payment under that paragraph, irrespective of any previous payment made in respect of that child under the provisions of this Section;
- (b) any payment under this Section in addition to any payment made in respect of a final completing vaccination administered to the same child under the pneumococcal catch-up campaign provided for under Section 8B, other than where—
 - (i) the contractor claims for payment for a final completing vaccination administered under the circumstances set out in paragraph 8A.13, and

- (ii) that final completing vaccination is in addition to any final completing vaccination administered under the provisions of Section 8B.

Claims for payment

8A.19 The contractor is to submit claims in respect of final completing vaccinations after they have been administered. The amount payable is to fall due quarterly on the last day of the quarter after the last quarter in which the vaccinations were carried out, in-line with the target Childhood Immunisations.

8A.20 Health Boards must ensure that the receipt and payment in respect of any claims are properly recorded and that each such claim has a clear audit trail.

Conditions attached to payment

8A.21 A payment under the provisions of this Section is only payable if the contractor satisfies the following conditions—

(a) the contractor must supply the Health Board with the following information in respect of each child for which a payment is claimed—

- (i) the name of the child;
- (ii) the CHI number of the child.
- (iii) subject to paragraph (iv) below, confirmation that the child has received three doses of PCV and one dose of Hib/MenC in accordance with the table at paragraph 8A.8;
- (iv) if the claim is made in the circumstances set out in paragraph 8A.12, 8A.13 or 8A.15, confirmation that all required vaccinations have been administered, and
- (v) the date of the final completing vaccination, which must have been administered by the contractor,

but where a parent or carer objects to details of the child's name being supplied to the Health Board, the contractor need not supply such information to the Health Board but must supply the child's CHI number;

(b) the contractor must provide appropriate information and advice to the parent or carer of the child, and, where appropriate, also to the child, about pneumococcal vaccinations and the Hib/MenC booster vaccination;

(c) the contractor must record in the child's records, kept in accordance with paragraph 66 of Schedule 5 to the 2004 Regulations, any refusal of an offer of a pneumococcal vaccination or a Hib/MenC Booster vaccination;

(d) where a pneumococcal vaccination or a Hib/MenC booster vaccination is administered, the contractor must record in the child's records, kept in accordance with paragraph 66 of Schedule 5 to the 2004 Regulations, those matters set out in paragraph 5(2)(d) of Schedule 1 to the 2004 Regulations;

(e) the contractor must ensure that any health care professional who performs any clinical service in connection with the administration of the vaccine has such clinical experience and training as are necessary to enable him to properly perform such



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services and that such health care professionals are trained in the recognition and initial treatment of anaphylaxis;

(f) the contractor must make available to the Health Board any information which the Health Board does not have but needs, and the contractor either has or could be reasonably expected to obtain, in order to form its opinion on whether the contractor is eligible for payment under the provisions of this Section;

(g) the contractor must make any returns required of it (whether computerised or otherwise) to the Practitioner Services Division (PSD) of NHS National Services Scotland, and do so promptly and fully; and

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

8A.22 If the contractor breaches any of these conditions, the Health Board may, in appropriate circumstances, withhold payment of any, or any part of, the payment due under this Section.

8B. Administration of Pneumococcal Vaccination as part of the Pneumococcal Catch-up Campaign

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

8B.2 Childhood immunisation and pre-school booster services are classified as Additional Services. This Section makes provision in respect of payments in respect of the administration by a contractor, which is contracted to provide the childhood immunisation and pre-school booster Additional Service, of the pneumococcal conjugate vaccine (PCV) as part of the catch-up programme for children who were aged over two months but under 2 years on 4th September 2006 and who, because they had already started their routine immunisation programme, cannot receive the three PCV vaccinations in accordance with the schedule in the table set out in paragraph 8A.8.

8B.3 The provisions of this Section apply with effect from 4th September 2006.

8B.4 Payments in respect of the administration by a contractor, which is contracted to provide childhood immunisation and pre-school booster Additional Services, of the pneumococcal conjugate vaccine (PCV) and the combined Hib and Men C booster vaccine (Hib/MenC) as part of the routine childhood immunisation schedule, and in certain non-routine cases, are dealt with separately in Section 8A.

8B.5 References in this Section to the age of a child expressed in months are references to calendar months. Where reference is made to a vaccination being administered at or around a certain age, this is an indication of the recommended schedule for administration of the vaccine contained in the provisions as set out in Annex I to this SFE. The specific timing of the administration of the vaccination, which should be within the parameters of the recommended schedule, is a matter for the clinical judgement of the relevant health care professional.

Payment for administration of PCV vaccinations as part of the Pneumococcal Catch-up campaign

8B.6 The pneumococcal catch-up campaign is aimed at the cohort of children who are over 2 months and under 2 years on 4th September 2006 and who consequently do not receive their PCV vaccinations as part of their routine childhood immunisations in accordance with the schedule set out at paragraph 8A.8. The aim of the catch-up campaign is to ensure that the target cohorts are offered vaccinations appropriate to their age within 6 months of 4th September 2006.

8B.7 The Health Board must pay to a contractor who qualifies for the payment, a payment of £7.51 in respect of each child registered with the contractor —

(a) who has received, as part of the pneumococcal catch-up campaign, the vaccinations set out in the table in paragraph 8B.8 appropriate to their age group; and

(b) in respect of whom the contractor administered the final completing vaccination, as determined by reference to the third column in the table in paragraph 8B.8.

8B.8 The table below sets out the schedule for the administration of the PCV vaccinations as part of the pneumococcal catch-up campaign.

Age group	Vaccination required and when required	Final completing vaccination	How the vaccine is given
Children born between 5th September 2004 and 3rd August 2005	One dose of PCV to be administered between 4th September 2006 and 31st March 2007	The final completing vaccination is the dose of PCV administered between 4th September 2006 and 31st March 2007	One injection
Children born between 4th August 2005 and 3rd February 2006	One dose of PCV to be administered to the child around the age of 13 months	The final completing vaccination is the dose of PCV administered around the age of 13 months	One injection
Children born between 4 th February 2006 and 3rd July 2006	Two doses of PCV, separated by a period of two months, before the age of 12 months and followed by a further dose of PCV around the age of 13 months	The final completing vaccination is the third of the three required doses of PCV which is administered to the child around the age of 13 months	On each occasion one injection

Eligibility for payment

8B.9 A contractor is only eligible for a payment under this Section in circumstances where the following conditions are met—

- (a) the contractor is contracted to provide the childhood immunisation and pre-school booster Additional Service;
- (b) the child in respect of whom the payment is claimed was on the contractor's list of registered patients at the time the final completing vaccination was administered;
- (c) the contractor administers the final completing vaccination to the child in respect of whom the payment is claimed;
- (d) the child in respect of whom the payment is claimed was, on 4th September 2006, aged over two months and under 2 years;
- (e) the contractor does not receive any payment from any other source in respect of any of the PCV vaccinations (if he does receive any such payment in respect of any child from any other source, the Health Board must give serious consideration to recovering any payment made under this Section in respect of that child pursuant to paragraph 21.1(a); and
- (f) the contractor submits the claim within 6 months of administering the final completing vaccination.

8B.10 The Health Board may set aside the requirement that the contractor submit the claim within 6 months of administering the final completing vaccination if it considers it reasonable to do so.

8B.11 The contractor is not entitled to —

- (a) payment of more than £7.51 in respect of any child under this Section.
- (b) any payment under this Section in addition to any payment made in respect of a final completing vaccination administered to the same child under the provisions of Section 8A, other than where —
 - (i) the contractor claims for payment for a final completing vaccination administered under the circumstances set out in paragraph 8A.13, and
 - (ii) that final completing vaccination is in addition to any final completing vaccination administered under the provisions of this Section.

Claims for payment

8B.12 The contractor is to submit claims in respect of final completing vaccinations after they have been administered. The amount payable is to fall due quarterly on the last day of the quarter after the last quarter in which the vaccinations were carried out, in-line with the target Childhood Immunisations.

8B.13 Health Boards must ensure that the receipt and payment in respect of any claims are properly recorded and that each such claim has a clear audit trail.

Conditions attached to payment

8B.14 A payment under the provisions of this Section is only payable if the contractor satisfies the following conditions—

- (a) the contractor must supply the Health Board with the following information in respect of each child for which a payment is claimed—
 - (i) the name of the child,
 - (ii) the CHI number of the child,
 - (iii) confirmation that the child has received the required dose or doses of PCV in accordance with the table at paragraph 8B.8, and
 - (iv) the date of the final completing vaccination, which must have been administered by the contractor,

but where a parent or carer objects to details of the child's name being supplied to the Health Board, the contractor need not supply such information to the Health Board but must supply the child's CHI number;

- (b) the contractor must provide appropriate information and advice to the parent or carer of the child, and, where appropriate, also to the child, about pneumococcal vaccinations;

- (c) the contractor must record in the child's records, kept in accordance with paragraph 66 of Schedule 5 to the 2004 Regulations, any refusal of an offer of a pneumococcal vaccination;

- (d) where a pneumococcal vaccination is administered, the contractor must record in the child's records, kept in accordance with paragraph 66 of Schedule 5 to the 2004 Regulations, those matters set out in paragraph 5(2)(d) of Schedule 1 to the 2004 Regulations;

- (e) the contractor must ensure that any health care professional who performs any clinical service in connection with the administration of the vaccine has such clinical experience and training as are necessary to enable him to properly perform such services and that such health care professionals are trained in the recognition and initial treatment of anaphylaxis;

- (f) the contractor must make available to the Health Board any information which the Health Board does not have but needs, and the contractor either has or could be reasonably expected to obtain, in order to form its opinion on whether the contractor is eligible for payment under the provisions of this Section;

- (g) the contractor must make any returns required of it (whether computerised or otherwise) to the Practitioner Services Division (PSD) of NHS National Services Scotland, and do so promptly and fully; and

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

8B.15 If the contractor breaches any of these conditions, the Health Board may, in appropriate circumstances, withhold payment of any, or any part of, the payment due under this Section.

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

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

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

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

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

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

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

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

- (d) the contractor is not also claiming another payment for locum cover in respect of the performer on leave pursuant to this Part,

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

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

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

Ceilings on the amounts payable

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

- (a) in respect of the first two weeks for which the Health Board provides reimbursement in respect of locum cover, £978.91 per week, and
- (b) in respect of any week thereafter for which the Health Board provides reimbursement in respect of locum cover, £1500 per week.

Payment arrangements

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

Conditions attached to the amounts payable

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

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

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

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

10. Payments for locums covering sickness leave

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

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

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

Entitlement to payments for covering sickness leave

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

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

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

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

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

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

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

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

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

Ceilings on the amounts payable

10.5 The maximum amount payable under this Section by the Health Board in respect of locum cover for a GP performer is £978.91 per week.

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

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

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

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

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

Payment arrangements

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

Conditions attached to the amounts payable

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

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

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

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

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

11. Payments for locums to cover for suspended doctors

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

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

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

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

Eligible cases

11.3 In any case where a contractor–

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

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

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

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

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

Ceilings on the amounts payable

11.5 The maximum amount payable under this Section by the Health Board in respect of locum cover for a GP performer is £978.91 per week.

Payment arrangements

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

Conditions attached to the amounts payable

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

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

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

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

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

12. Payments in respect of Prolonged Study Leave

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

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

Types of study in respect of which prolonged study leave may be taken

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

- (a) the study leave is for at least 10 weeks but not more than 12 months;
- (b) the educational aspects of the study leave have been approved by the local Director of Postgraduate GP Education, having regard to any guidance on Prolonged Study Leave that Directors of Postgraduate GP Education have agreed nationally; and

- (c) the Health Board has determined that the payments to the contractor under this Section in respect of the Prolonged Study Leave are affordable, having regard to the budgetary targets it has set for itself.

The educational allowance payment

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

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

Locum cover in respect of doctors on Prolonged Study Leave

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

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

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

12.7 The maximum amount payable under this Section by the Health Board in respect of locum cover for a GP performer is £978.91 per week.

Payment arrangements

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

Conditions attached to the amounts payable

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

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

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

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

13. Seniority payments

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

Eligible posts

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

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

Service that is Reckonable Service

13.3 Work shall be counted as Reckonable Service if–

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

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

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

- (d) it is service with the Foreign and Commonwealth Office as a medical officer in a diplomatic mission abroad, if accepted by the Health Board or endorsed by Scottish Ministers as Reckonable Service; or
- (e) it comprises up to a maximum of four years clinical service in a country or territory outside the United Kingdom—
 - (i) which followed the date of first registration of the GP provider in that country or territory, and
 - (ii) in circumstances where—
 - (aa) on 31st March 2003, that period of clinical service was counted by a Health Board as a period of registration for the purposes of a calculation of the annual rate of the GP Provider's Seniority Payment under the Red Book, and
 - (bb) that period of clinical service is not counted as reckonable service by virtue of any of the preceding sub-paragraphs in this paragraph.

Calculation of years of Reckonable Service

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

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

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

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

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

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

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

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

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

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

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

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

Determination of the relevant dates

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

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

Calculation of the full annual rate of Seniority Payments

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

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

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

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

TABLE

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

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

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

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

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

Superannuable Income Fractions

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

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

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

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

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

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

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

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

Amounts payable

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

13.19 If, however, the GP provider's—

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

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

Conditions attached to payment of Quarterly Seniority Payments

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

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

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

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

14. Golden Hello Scheme

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

Standard payments under the Golden Hello Scheme

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

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

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

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

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

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

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

Additional payments under the Golden Hello Scheme

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

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

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

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

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

Job Sharers

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

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

Changes in Circumstances

Extra payments

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

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

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

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

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

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

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

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

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

Return of Payments

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

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

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

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

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

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

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

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

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

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

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

Relocation Costs

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

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

Recruitment Costs

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

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

Rates of Payment

14.23 Rates of payment will be at the following rates.

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

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

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

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

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

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

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

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

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

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

16. NOT ALLOTTED

17. Doctors' Retainer Scheme

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

Payments in respect of sessions undertaken by members of the Scheme

17.2 Subject to paragraph 17.2A, where—

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

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

Provisions in respect of leave arrangements

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

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

- (f) other pressing personal or family reasons where the contractor and the Health Board agree that the absence of the member of the Doctors' Retainer Scheme is necessary and unavoidable.

Payment conditions

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

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

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

18. Dispensing

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

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

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

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

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

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

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

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

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

18.6 Where additional expenses have been incurred in obtaining from a manufacturer or wholesaler supplies of a drug or appliance (other than those items for which prices are given in Parts 2-5, 7 and 9 of the Tariff), which a practice does not frequently require to provide, payment of the amount incurred will be authorised if the practice submits a claim giving full details to the Health Board with the appropriate prescription form and if, in any doubtful cases, the Health Board, after consultation with the GP Subcommittee of the Area Medical Committee, is satisfied that the additional expenses were necessarily incurred and were reasonable.

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

18.8 Where

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

that by reason of

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

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

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

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

Transitional Arrangements

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

Claims

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

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

Payments On Account

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

Examination Of Prescription Forms

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

Accounting

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

Patient Charges

18.15 All reimbursements made under this section in respect of dispensings made from 1 January 2006 onwards will be subject to deduction of the appropriate patient charge, except where the prescription is duly endorsed by the patient, their representative or the practice, to claim exemption from charges.

18.16 The provisions set out in paragraphs 18.1 to 18.5 do not cover remuneration and reimbursement arrangements for dispensing doctors in respect of the provision of influenza vaccine. Specific arrangements in relation to this for 2008-09 are detailed in NHS Circular PCA(P)(2008)23 issued on 16 December 2008.

PARAGRAPH 18/SCHEDULE 1

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

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

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

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

PARAGRAPH 18/SCHEDULE 2

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

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

1051-1100	88.2
1101-1150	83.7
1151-1200	81.7
1201-1250	76.7
1251-1300	74.7
1301-1350	70.2
1351-1400	64.2
1401-1450	62.2
1451-1500	57.2
1501-1750	84.7
1751-2000	94.7
2001-2250	92.7
2251-2500	90.2
2501-2750	88.7
2751-3000	86.2
3001-3250	85.7
3251-3500	84.7
3501-3750	83.2
3751-4000	82.7

4001-4250	81.7
4251-4500	79.7
4501-4750	78.7
4751-5000	77.7
5001-5250	77.2
5251-5500	75.7
5501-5750	74.7
5751-6000	73.7
6001-6250	72.7
6251-6500	71.7
6501-6750	70.7

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

PARAGRAPH 18/SCHEDULE 3

ADDRESSES TO WHICH DISPENSING PRACTICES SHOULD SUBMIT THEIR CLAIMS

Practitioner Services Division (Pharmacy)

3 Bain Square

Livingston

EH54 7DQ

PARAGRAPH 18/ SCHEDULE 4

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

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

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

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

PART 5

19 PREMISES

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

20. IT Expenses

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

PART 6

SUPPLEMENTARY PROVISIONS

21. Administrative Provisions

Overpayments and withheld amounts

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

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

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

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

Underpayments and late payments

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

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

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

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

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

21.5 However, if a contractor has—

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

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

Payments on account

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

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

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

21.7 Health Boards will not be able to calculate the correct amount of GP providers' Seniority Payments during the financial year to which they relate because it will not be possible to calculate the correct value of the GP provider's Superannuable Income Fraction until—

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

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

Payments to or in respect of suspended doctors whose suspension ceases

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

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

Effect on periodic payments of termination of a GMS contract

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

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

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

Time limitation for claiming payments

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

Dispute resolution procedures

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

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

Protocol in respect of locum cover payments

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

21.14 As a supplementary measure, Health Boards are directed to adopt and keep-up-to-date a protocol, which they must take all reasonable steps to agree with any

relevant GP sub-committee of the area medical committee, setting out in reasonable detail–

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

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

Adjustment of Contractor Registered Populations

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

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

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

that patient is to be treated as part of the contractor's Contractor Registered Population at the start of that quarter.

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

- (a) within 10 days of receiving from the Health Board a statement of its patient list size for a quarter, request in writing that the Health Board makes the adjustment; and
- (b) within 21 days of receiving that statement, provide the Health Board with the evidence upon which it wishes to rely in order to obtain the adjustment.

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

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

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

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

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

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

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

the third quarter of the financial year 2005 to 2006, as are all the payments that are or were due to fall due pursuant to this SFE in that third quarter or in the second quarter of that financial year; or

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

22. Superannuation contributions

Responsibilities in respect of contractors' employer's and employee's superannuation contributions

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

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

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

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

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

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

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

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

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

Monthly deductions in respect of superannuation contributions

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

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

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

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

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

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

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

End-year adjustments

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

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

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

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

made must nevertheless prepare, sign and forward the certificate to the Health Board so that the correct amount of their Seniority Payments may be determined.

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

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

Locums

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

ANNEX A

GLOSSARY

PART 1

ACRONYMS

The following acronyms are used in this document:

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

PART 2

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

“DES Directions” means the Primary Medical Services (Directed Enhanced Services) (Scotland) Directions 2006.

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

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

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

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

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

““General Practitioner” means—

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

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

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

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

“GP performer” means a general practitioner–

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

“GP provider” means a GP who is–

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

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

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

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

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

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

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

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

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

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

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

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

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

Pandemic Influenza (H1N1) Vaccination Scheme 2009 means the Primary Medical Services (Directed Enhanced Services- Pandemic Influenza (H1N1) Vaccination Scheme) (Scotland) 2009

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

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

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

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

“PMS contract” means section 17C arrangements.

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

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

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

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

“Quarter” means a quarter of the financial year.

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

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

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

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

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

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

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

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

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

ANNEX B

THE SCOTTISH ALLOCATION FORMULA (SAF) FOR GENERAL MEDICAL SERVICES

Introduction

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

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

The Scottish Allocation Formula

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

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

Adjusted for 'weightings' to reflect:

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

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

GP Practice Population

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

Demography

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

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

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

Note that the SAF age-sex ‘weightings’ are based on 2004/05 year data from the **Practice Team Information (PTI)** practices⁸ and are expressed relative to a male patient aged 5-14.

Additional Need

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

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

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

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

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

Remote and Rural Areas

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

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

⁸ Approximately 45 practices in Scotland provide monthly consultation returns to the PTI database.

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

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

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

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

The Weighted Practice Population

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

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

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

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

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

Table - Illustrated Example

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

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

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

Minimum Practice Income Guarantee (MPIG)

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

Summary

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

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

ANNEX C

TEMPORARY PATIENTS ADJUSTMENT

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

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

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

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

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

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

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

ANNEX D - NOT ALLOTTED

Annex E

Quality and Outcomes Framework

Guidance

Section 1. Principles

The following principles relating to the Quality and Outcomes Framework (QOF) 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. An appropriate balance has to be struck between excess data collection and inadequate sampling.
- 5 Data should never be collected twice i.e. 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. In this revision of the Quality and Outcomes Framework, indicators are no longer numbered sequentially. Where indicators have been removed from the Framework, their number has not been reallocated to new indicators.

Similarly where indicators have been amended, either in relation to the activity being measured or the frequency with which the activity should be completed, the indicator has been renumbered. The reason for this is to avoid inappropriate cross year comparisons between different indicators. Indicators have NOT been renumbered where the only change is in the threshold and range.

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. Rationale and reporting/verification

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 for each disease category. 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 (e.g. 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 QOF in each home country are based entirely on Read codes (4 byte, version 2 and Clinical Terms Version 3 and SNOMED) and associated dates. Read codes are an NHS standard. Practices using proprietary coding systems and/or local/practice specific codes need to be advised that these codes will not be recognised within QOF reporting. Practices utilising such systems should develop strategies to ensure that they are utilising appropriate Read codes in advance of producing their achievement report.

The Logical Query Indicator Specification and the Dataset and Business Rules are updated twice a year and can be downloaded from www.pcc.nhs.uk

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.

All reporting should be possible through the use of GP clinical systems and practices can run a report annually which can be submitted to the PCO. Separate guidance has been produced on the electronic queries which can be used to report on the Quality and Outcomes Framework in England. This can be found at the following location:

www.connectingforhealth.nhs.uk/delivery/programmes/qof/docs/establishing_accuracy_in_qof_data.pdf

Additional information on the process and content of QOF review visits in Scotland can be found at:

www.paymodernisation.scot.nhs.uk/gms/quality/index.htm

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.

PCOs may also wish to use these principles in the verification of other indicators

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

2. Exception reporting

The QOF 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 e.g. 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 e.g. blood pressure or cholesterol measurements within target levels
- D) patients who are on maximum tolerated doses of medication whose levels remain sub-optimal
- E) patients for whom prescribing a medication is not clinically appropriate e.g. those who have an allergy, 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 e.g. cholesterol reduction where the patient has liver disease
- I) where an investigative service or secondary care service is unavailable.

In the case of exception reporting on criteria A and B this would apply to the disease register and these patients would be subtracted from the denominator for all other indicators. For example, in a practice with 100 patients on the Coronary Heart Disease (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 heart failure due to 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.

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 QOF and this should be identifiable in the clinical record.

Exception reporting guidance can be found at the following location:

3. Disease registers

An important feature of the QOF 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 relatively blunt instrument and there are likely to be good reasons for variations but it is anticipated these will be discussed with practices. An explanation on how points are calculated and how prevalence will be applied can be found in the Statement of Financial Entitlements (SFE).

Summary of Indicators

Clinical Domain

Secondary Prevention of Coronary Heart Disease

Indicator	Points	Payment Stages
Records		
CHD 1. The practice can produce a register of patients with coronary heart disease	4	
Diagnosis and initial management		
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	40–90%
Ongoing Management		
CHD 5. The percentage of patients with coronary heart disease whose notes have a record of blood pressure in the previous 15 months	7	40-90%
CHD 6. The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the previous 15 months) is 150/90 or less	17	40-70%
CHD 7. The percentage of patients with coronary heart disease whose notes have a record of total cholesterol in the previous 15 months	7	40-90%
CHD 8. The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the previous 15 months) is 5 mmol/l or less	17	40-70%
CHD 9. The percentage of patients with coronary heart disease with a record in the previous 15 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken (unless a contraindication or side-effects are recorded)	7	40-90%
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	40-60%
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	40-80%
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	40-90%

Cardiovascular Disease –primary prevention

Indicator	Points	Payment stages
Initial diagnosis		
PP1 In those patients with a new diagnosis of hypertension (excluding those with pre-existing CHD,diabetes,stroke and/or TIA) recorded between the preceding 1 April to 31 March: the percentage of patients who have had a face to face cardiovascular risk assessment at the outset of diagnosis(within three months of the initial diagnosis) using an agreed risk assessment tool	8	40-70%
Ongoing management		
PP2. The percentage of people diagnosed with hypertension diagnosed after 1 April 2009 who are given lifestyle advice in the last 15 months for:increasing physical activity,smoking cessation,safe alcohol consumption and healthy diet	5	40-70%

Heart Failure

Indicator	Points	Payment stages
Records		
HF1: The practice can produce a register of patients with heart failure.	4	
Initial diagnosis		
HF2: The percentage of patients with a diagnosis of heart failure (diagnosed after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment.	6	40-90%
Ongoing management		
HF3: The percentage of patients with a current diagnosis of heart failure due to LVD who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker, who can tolerate therapy and for whom there is no contra-indication.	10	40-80%
HF 4. The percentage of patients with a current diagnosis of heart failure due to LVD who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker, who are additionally treated with a beta-blocker licensed for heart failure, or recorded as intolerant to or having a contraindication to beta-blockers.	9	40-60%

Stroke and Transient Ischaemic Attacks (TIA)

Indicator	Points	Payment Stages
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Records		
STROKE 1. The practice can produce a register of patients with Stroke or TIA	2	
STROKE 13. The percentage of new patients with a stroke or TIA who have been referred for further investigation.	2	40-80%
Ongoing Management		
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	40-90%
STROKE 6. The percentage of patients with a history of TIA or stroke in whom the last blood pressure reading (measured in the previous 15 months) is 150/90 or less	5	40-70%
STROKE 7. The percentage of patients with TIA or stroke who have a record of total cholesterol in the last 15 months	2	40-90%
STROKE 8. The percentage of patients with TIA or stroke whose last measured total cholesterol (measured in the previous 15 months) is 5 mmol/l or less	5	40-60%
STROKE 12. The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record that an anti-platelet agent (aspirin, clopidogrel, dipyridamole or a combination), or an anti-coagulant is being taken (unless a contraindication or side-effects are recorded)	4	40-90%
STROKE 10. The percentage of patients with TIA or stroke who have had influenza immunisation in the preceding 1 September to 31 March	2	40-85%

Hypertension

Indicator	Points	Payment Stages
Records		
BP 1. The practice can produce a register of patients with established hypertension	6	
Ongoing Management		
BP 4. The percentage of patients with hypertension in whom there is a record of the blood pressure in the previous 9 months	18	40-90%
BP 5. The percentage of patients with hypertension in whom the last blood pressure (measured in the previous 9 months) is 150/90 or less	57	40-70%

Diabetes Mellitus

Indicator	Points	Payment Stages
Records		
DM 19. The practice can produce a register of all patients aged 17 years and over with diabetes mellitus, which specifies whether the patient has Type 1 or Type 2 diabetes.	6	
Ongoing Management		
DM 2. The percentage of patients with diabetes whose notes record BMI in the previous 15 months	3	40-90%
DM 5. The percentage of patients with diabetes who have a record of HbA1c or equivalent in the previous 15 months	3	40-90%
DM 23. The percentage of patients with diabetes in whom the last HbA1c is 7 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months,	17	40-50%
DM 24. The percentage of patients with diabetes in whom the last HbA1c is 8 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months	8	40-70%
DM 25. The percentage of patients with diabetes in whom the last HbA1c is 9 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months	10	40-90%
DM 21. The percentage of patients with diabetes who have a record of retinal screening in the previous 15 months	5	40-90%
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	40-90%
DM 10. The percentage of patients with diabetes with a record of neuropathy testing in the previous 15 months	3	40-90%
DM 11. The percentage of patients with diabetes who have a record of the blood pressure in the previous 15 months	3	40-90%
DM 12. The percentage of patients with diabetes in whom the last blood pressure is 145/85 or less	18	40-60%
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	40-90%
DM 22. The percentage of patients with diabetes who have a record of estimated glomerular filtration rate (eGFR) or serum creatinine testing in the previous 15 months	3	40-90%
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	40-80%
DM 16. The percentage of patients with diabetes who have a record of total cholesterol in the previous 15 months	3	40-90%



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DM 17. The percentage of patients with diabetes whose last measured total cholesterol within the previous 15 months is 5 mmol/l or less	6	40-70%
DM 18. The percentage of patients with diabetes who have had influenza immunisation in the preceding 1 September to 31 March.	3	40-85%

Chronic Obstructive Pulmonary Disease

Indicator	Points	Payment Stages
Records		
COPD 1. The practice can produce a register of patients with COPD	3	
Initial diagnosis		
COPD 12. The percentage of all patients with COPD diagnosed after 1 st April 2008 in whom the diagnosis has been confirmed by post bronchodilator spirometry	5	40-80%
Ongoing management		
COPD 10. The percentage of patients with COPD with a record of FeV1 in the previous 15 months	7	40-70%
COPD 13. The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the MRC dyspnoea score in the preceding 15 months	9	50-90%
COPD 8. The percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March	6	40-85%

Epilepsy

Indicator	Points	Payment Stages
Records		
EPILEPSY 5. The practice can produce a register of patients aged 18 and over receiving drug treatment for epilepsy	1	
Ongoing Management		
EPILEPSY 6. The percentage of patients age 18 and over on drug treatment for epilepsy who have a record of seizure frequency in the previous 15 months	4	40-90%

EPILEPSY 7. The percentage of patients age 18 and over on drug treatment for epilepsy who have a record of medication review involving the patient and/or carer in the previous 15 months	4	40-90%
EPILEPSY 8. The percentage of patients age 18 and over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the previous 15 months	6	40-70%

Hypothyroid

Indicator	Points	Payment stages
Records		
THYROID 1. The practice can produce a register of patients with hypothyroidism	1	
Ongoing Management		
THYROID 2. The percentage of patients with hypothyroidism with thyroid function tests recorded in the previous 15 months	6	40-90%

Cancer

Indicator	Points	Payment stage
Records		
CANCER 1. The practice can produce a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers from 1 April 2003'	5	
Ongoing Management		
CANCER 3. The percentage of patients with cancer, diagnosed within the last 18 months who have a patient review recorded as occurring within 6 months of the practice receiving confirmation of the diagnosis	6	40-90%

Palliative Care

Indicator	Points	Payment Stages
Records		
PC3: The practice has a complete register available of all patients in need of palliative care/support irrespective of age	3	
Ongoing Management		

PC2: The practice has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed.	3	
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Mental Health

Indicator	Points	Payment stages
Records		
MH 8. The practice can produce a register of people with schizophrenia, bipolar disorder and other psychoses	4	
Ongoing management		
MH 9. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses with a review recorded in the preceding 15 months. In the review there should be evidence that the patient has been offered routine health promotion and prevention advice appropriate to their age, gender and health status	23	40-90%
MH 4. The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 15 months	1	40-90%
MH 5. The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the previous 6 months	2	40-90%
MH6: The percentage of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate	6	25-50%
MH7: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who do not attend the practice for their annual review who are identified and followed up by the practice team within 14 days of non-attendance	3	40-90%

Asthma

Indicator	Points	Payment stages
Records		
ASTHMA 1. The practice can produce a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the previous twelve months	4	
Initial Management		
ASTHMA 8. The percentage of patients aged eight and over diagnosed as having asthma from 1 April 2006 with measures of	15	40-80%

variability or reversibility		
Ongoing management		
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	40-80%
ASTHMA 6. The percentage of patients with asthma who have had an asthma review in the previous 15 months	20	40-70%

Dementia

Indicator	Points	Payment Stages
Records		
DEM1: The practice can produce a register of patients diagnosed with dementia	5	
Ongoing management		
DEM2: The percentage of patients diagnosed with dementia whose care has been reviewed in the previous 15 months	15	25-60%

Depression

Indicator	Points	Payment Stages
Diagnosis and initial management		
DEP1: The percentage of patients on the diabetes register and /or the CHD register for whom case finding for depression has been undertaken on one occasion during the previous 15 months using two standard screening questions	8	40-90%
DEP2: In those patients with a new diagnosis of depression, recorded between the preceding 1 April to 31 March, the percentage of patients who have had an assessment of severity at the outset of treatment using an assessment tool validated for use in primary care	25	40-90%
DEP3: In those patients with a new diagnosis of depression and assessment of severity recorded between the preceding 1 April to 31 March, the percentage of patients who have had a further assessment of severity 5-12 weeks (inclusive) after the initial recording of the assessment of severity. Both assessments should be completed using an assessment tool validated for use in primary care.	20	40-90%

Chronic Kidney Disease (CKD)

Indicator	Points	Payment stages
Records		
CKD1: The practice can produce a register of patients aged 18 years and over with CKD (US National Kidney Foundation: Stage 3 to 5 CKD)	6	
Initial Management		
CKD2: The percentage of patients on the CKD register whose notes have a record of blood pressure in the previous 15 months	6	40-90%
Ongoing Management		
CKD3: The percentage of patients on the CKD register in whom the last blood pressure reading, measured in the previous 15 months, is 140/85 or less	11	40-70%
CKD5: The percentage of patients on the CKD register with hypertension and proteinuria who are treated with an angiotensin converting enzyme inhibitor (ACE-I) or angiotensin receptor blocker (ARB) (unless a contraindication or side effects are recorded)	9	40-80%
CKD 6. The percentage of patients on the CKD register whose notes have a record of a urine albumin: creatinine ratio (or protein: creatinine ratio) test in the previous 15 months	6	40-80%

Atrial Fibrillation

Indicator	Points	Payment Stages
Records		
AF1: The practice can produce a register of patients with atrial fibrillation.	5	
Initial diagnosis		
AF4: The percentage of patients with atrial fibrillation diagnosed after 1 April 2008 with ECG or specialist confirmed diagnosis.	10	40-90%
Ongoing management		
AF3: The percentage of patients with atrial fibrillation who are currently treated with anti-coagulation drug therapy or an anti-platelet therapy.	12	40-90%

Obesity

Indicator	Points	Payment Stages
Records		
OB1: The practice can produce a register of patients aged 16 and over with a Body Mass Index (BMI) greater than or equal to 30 in the previous 15 months.	8	

Learning Disabilities

Indicator	Points	Payment Stages
Records		
The practice can produce a register of patients with learning disabilities	4	

Smoking Indicators

Indicator	Points	Payment Stages
Ongoing management		
Smoking 3: The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the previous 15 months.	30	40-90%
Smoking 4: The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who smoke whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered within the previous 15 months	30	40-90%

Organisational Domain

Records and Information

	Indicator	Points
Records 3	The practice has a system for transferring and acting on information about patients seen by other doctors out of hours	1
Records 8	There is a designated place for the recording of drug allergies and adverse reactions in the notes and these are clearly recorded	1
Records 9	For repeat medicines, an indication for the drug can be identified in the records (for drugs added to the repeat prescription with effect from 1 April 2004). Minimum Standard 80%	4
Records 11	The blood pressure of patients aged 45 and over is recorded in the preceding 5 years for at least 65% of patients	10
Records 13	There is a system to alert the out-of-hours service or duty doctor to patients dying at home	2
Records 15	The practice has up-to-date clinical summaries in at least 60% of patient records	25
Records 17	The blood pressure of patients aged 45 and over is recorded in the preceding 5 years for at least 80% of patients	5
Records 18	The practice has up-to-date clinical summaries in at least 80% of patient records	8
Records 19	80% of newly registered patients have had their notes summarised within 8 weeks of receipt by the practice	7
Records 20	The practice has up-to-date clinical summaries in at least 70% of patient records	12
Records 21	Ethnic origin is recorded for 100% of new registrations	1
Records 23	The percentage of patients aged over 15 years whose notes record smoking status in the past 27 months (payment stages 40 – 90%)	11

Information for Patients

	Indicator	Points
Information 4	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	1
Information 5	The practice supports smokers in stopping smoking by a strategy which includes providing literature and offering	2

	appropriate therapy	
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Education and Training

	Indicator	Points
Education 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	4
Education 5	There is a record of all practice-employed staff having attended training/updating in basic life support skills in the preceding 36 months	3
Education 6	The practice conducts an annual review of patient complaints and suggestions to ascertain general learning points which are shared with the team	3
Education 7	<p>The practice has undertaken a minimum of twelve significant event reviews in the past 3 years which could include:</p> <ul style="list-style-type: none"> • Any death occurring in the practice premises • New cancer diagnoses • Deaths where terminal care has taken place at home • Any suicides • Admissions under the Mental Health Act • Child protection cases • Medication errors. <p>A significant event occurring when a patient may have been subjected to harm, had the circumstance/ outcome been different (near miss)</p>	4
Education 8	All practice-employed nurses have personal learning plans which have been reviewed at annual appraisal	5
Education 9	All practice-employed non-clinical team members have an annual appraisal	3
Education 10	The practice has undertaken a minimum of three significant event reviews within the last year	6

Practice Management

	Indicator	Points
Management 1	Individual healthcare professionals have access to information on local procedures relating to Child Protection	1
Management 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	1
Management 3	The Hepatitis B status of all doctors and relevant practice-employed staff is recorded and immunisation recommended	0.5

	if required in accordance with national guidance	
Management 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 with the PCO	3
Management 7	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"> • A defined responsible person • Clear recording • Systematic pre-planned schedules • Reporting of faults 	3
Management 9	The practice has a protocol for the identification of carers and a mechanism for the referral of carers for social services assessment	3
Management 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	2

Medicines Management

	Indicator	Points
Medicines 2	The practice possesses the equipment and in-date emergency drugs to treat anaphylaxis	2
Medicines 3	There is a system for checking the expiry dates of emergency drugs on at least an annual basis	2
Medicines 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)	3
Medicines 6	The practice meets the PCO prescribing adviser at least annually and agrees up to three actions related to prescribing	4
Medicines 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)	6
Medicines 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	4
Medicines 11	A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed four or more repeat medicines. Standard 80%	7
Medicines 12	A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed repeat medicines. Standard 80%	8

Patient Experience Domain

Indicator	Points	Payment stages
<p>PE 1 Length of Consultations</p> <p>The length of routine booked appointments with the doctors in the practice is not less than 10 minutes. (If the practice routinely sees extras during booked surgeries, then the average booked consultation length should allow for the average number of extras seen in a surgery session. If the extras are seen at the end, then it is not necessary to make this adjustment).</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>	33	
<p>PE 7 Patient experience of access (1)</p> <p>The percentage of patients who, in the appropriate national survey, indicate that they were able to obtain a consultation with a GP (in England) or appropriate health care professional (in Scotland, Wales and NI) within 2 working days (in Wales this will be within 24 hours)</p>	23.5	70-90%
<p>PE 8 Patient experience of access (2)</p> <p>The percentage of patients who, in the appropriate national survey, indicate that they were able to book an appointment with a GP more than 2 days ahead</p>	35	60-90%

Additional Services

For practices providing additional services the following organisational markers will apply.

Cervical Screening (CS)

	Indicator	Points
CS 1	The percentage of patients aged from 25 to 64 (in Scotland from 21 to 60) whose notes record that a cervical smear has been performed in the last five years Standard 40 – 80%	11
CS 5	The practice has a system for informing all women of the results of cervical smears	2
CS 6	The practice has a policy for auditing its cervical screening service, and performs an audit of inadequate cervical smears in relation to individual smear-takers at least every 2 years	2
CS 7	The practice has a protocol that is in line with national guidance and practice for the management of cervical screening, which includes staff training, management of patient call/ recall, exception reporting and the regular monitoring of inadequate smear rates	7

Child Health Surveillance (CHS)

	Indicator	Points
CHS 1	Child development checks are offered at intervals that are consistent with national guidelines and policy	6

Maternity Services (MAT)

	Indicator	Points
MAT 1	Ante-natal care and screening are offered according to current local guidelines	6

Contraception (SH)

	Indicator	Points
SH 1	The practice can produce a register of women who have been prescribed any method of contraception at least once in the last year, or other appropriate interval e.g. last 5 years for an IUS.	4
SH 2	The percentage of women prescribed an oral or patch contraceptive method who have also received information from the practice about long acting reversible methods of contraception in the previous 15 months. (payment stages 40 – 90%)	3
SH 3	The percentage of women prescribed emergency hormonal contraception at least once in the year by the practice who have received information from the practice about long acting reversible methods of contraception at the time of, or within one month of, the prescription. (payment stages 40 – 90%)	3

Secondary Prevention in Coronary Heart Disease (CHD)

Indicator	Points	Payment Stages
Records		
CHD 1. The practice can produce a register of patients with coronary heart disease	4	
Diagnosis and initial management		
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	40–90%
Ongoing Management		
CHD 5. The percentage of patients with coronary heart disease whose notes have a record of blood pressure in the previous 15 months	7	40-90%
CHD 6. The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the previous 15 months) is 150/90 or less	17	40-70%
CHD 7. The percentage of patients with coronary heart disease whose notes have a record of total cholesterol in the previous 15 months	7	40-90%
CHD 8. The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the previous 15 months) is 5 mmol/l or less	17	40-70%
CHD 9. The percentage of patients with coronary heart disease with a record in the previous 15 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken (unless a contraindication or side-effects are recorded)	7	40-90%
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	40-60%
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	40-80%
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	40-90%

CHD - Rationale for Inclusion of Indicator Set

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

CHD Indicator 1

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

CHD 1.1 Rationale

In order to call and recall patients effectively in any disease category and in order to be able to report on indicators for 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 QOF does not specify how the diagnosis of angina is made or confirmed. This will vary from patient to patient, e.g. 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 96

Further Information: <http://www.sign.ac.uk/guidelines/fulltext/96/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 96

Further Information: www.sign.ac.uk/guidelines/fulltext/96/index.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 QOF an appropriate referral being undertaken between three months before and twelve months after a diagnosis of angina has been 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:

- i. Inspection of the output from a computer search that has been used to provide information on this indicator.
- ii. 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.
- iii. 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 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 their 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 previous 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.

Further Information: (http://www.bhsoc.org/NICE_BHS_Guidelines.stm).

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 taken in the previous 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 Guidelines 93, 96, 97

Further Information: www.sign.ac.uk/guidelines/fulltext/93-97/index.html

It is unclear from the literature how frequently cholesterol measurement should be undertaken, but the English National 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 previous 15 months.

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

- i. Inspection of the output from a computer search that has been used to provide information on this indicator.
- ii. Inspection of a sample of records of patients with CHD to look at the proportion with recorded serum cholesterol.
- iii. 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 the previous 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). Recent trials have found greater relative benefit with more potent cholesterol lowering regimes. It is likely that National Guidelines relating to statin therapy in patients with CHD will change to recommend statin therapy for all patients with CHD irrespective of their starting level of total cholesterol.

However, currently the Joint British Recommendations on Prevention of Coronary Heart Disease in Clinical Practice (1998) and SIGN Guidelines 93, 96 and 97 recommend that patients who have a cholesterol of greater than 5mmol/l should be offered lipid lowering therapy. This should be treated as an audit target below which to aim for all eligible CHD patients.

The guidance here is given in terms of total cholesterol, as this is used in national guidance and in trials.

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 previous 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 PCO:

- i. Inspection of the output from a computer search that has been used to provide information on this indicator.
- ii. Inspection of a sample of records of patients with CHD to look at the proportion with recorded serum cholesterol 5mmol/l or less.
- iii. 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 previous 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 96 and 97

Further Information:

<http://www.sign.ac.uk/guidelines/fulltext/96/index.html>

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

Since the original GMS Guidance in 2003, NICE have released guidance on the appropriate use of clopidogrel:

- Clopidogrel alone (within its licensed indications) is recommended for people who are intolerant of low-dose aspirin and either have experienced an occlusive vascular event or have symptomatic peripheral artery disease. NICE define aspirin intolerance as either of the following: proven hypersensitivity to aspirin-containing medicines or history of severe dyspepsia induced by low-dose aspirin.
- Clopidogrel, in combination with low-dose aspirin, is recommended for use in the management of non-ST-segment-elevation acute coronary syndrome (ACS) in people who are at moderate to high risk of myocardial infarction (MI) or death. NICE recommend that treatment with clopidogrel in combination with low-dose aspirin should be continued for up to 12 months after the most recent acute episode of non-ST-segment-elevation ACS. Thereafter, standard care, including treatment with low-dose aspirin alone, is recommended. Moderate to high risk of MI or death in people presenting with

non-ST-segment-elevation ACS can be determined by clinical signs and symptoms, accompanied by one or both of the following:

- i. The results of clinical investigations, such as new ECG changes (other than persistent ST-segment-elevation), indicating ongoing myocardial ischaemia, particularly dynamic or unstable patterns.
- ii. The presence of raised blood levels of markers of cardiac cell damage such as troponin.

Further information:

<http://www.nice.org.uk/guidance/index.jsp?action=byID&r=true&o=11536>

<http://www.nice.org.uk/Guidance/TA80>

<http://www.nice.org.uk/Guidance/TA90>

CHD 9.2 Reporting and Verification.

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

Recent evidence against the use of beta blockers in hypertension should not be extrapolated to patients with CHD.

Grade A Recommendation SIGN Guidelines 96 and 97

Further Information: www.sign.ac.uk/guidelines/fulltext/96/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 six 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.

Grade A Recommendation SIGN Guideline 96

Grade A Recommendation NICE Guideline A

Further Information:

www.sign.ac.uk/guidelines/fulltext/96/index.html

<http://www.escardio.org/Pages/index.aspx?hit=quick>

<http://www.escardio.org/guidelines-surveys/esc-guidelines/Pages/GuidelinesList.aspx>

CHD 11.2 Reporting and Verification.

The percentage of patients who have had a myocardial infarction after 1 April 2003 whose records show they have been prescribed an ACE inhibitor or A2 antagonist in the last six 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.

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.

Cardiovascular disease – primary prevention

Indicator	Points	Payment stages
Initial diagnosis		
PP 1. In those patients with a new diagnosis of hypertension (excluding those with pre-existing CHD, diabetes, stroke and/or TIA) recorded between the preceding 1 April to 31 March: the percentage of patients who have had a face to face cardiovascular risk assessment at the outset of diagnosis (within three months of the initial diagnosis) using an agreed risk assessment tool.	8	40-70%
Ongoing management		
PP 2. The percentage of people diagnosed with hypertension diagnosed after 1 April 2009 who are given lifestyle advice in the last 15 months for: increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet.	5	40-70%

Cardiovascular disease – primary prevention - rationale for inclusion of indicator set

CVD is the commonest cause of death in the UK, and importantly for patients, the major cause of premature death (before 65). Moreover, of greater significance for the NHS, CVD is now the commonest cause of disability (through stroke and heart failure particularly) and hospital admission. This results in CVD being the major cost driver for health utilisation and remains the end point disease for many other chronic disorders, especially diabetes and renal disease.

Primary prevention (PP) works and evidence based interventions can dramatically reduce risk – in North Karelia which had the highest CVD rates in Europe 25 years ago, CVD mortality has reduced by 50% through rigid implementation of public health and individual patient interventions. An analysis of CHD trends in Ireland found that over a 15 year period, primary prevention achieved a two-fold larger reduction in CHD deaths than secondary prevention, with 68% of the 2530 fewer deaths attributable to CHD (using the IMPACT CHD mortality model) having occurred in people without recognised CHD compared to 32% in CHD patients⁹.

⁹ Kabir Z., Bennett K., Shelley E., Unal B., Critchley J., Capewell S. Comparing primary prevention with secondary prevention to explain decreasing Coronary Heart Disease death rates in Ireland, 1985-2000. BMC Public Health 2007, 7:17

Primary prevention (PP) indicator 1

PP 1. In those patients with a new diagnosis of hypertension (excluding those with pre-existing CHD, diabetes, stroke and/or TIA) recorded between the preceding 1 April to 31 March: the percentage of patients who have had a face to face cardiovascular risk assessment at the outset of diagnosis using an agreed risk assessment tool.

Primary prevention 1.1 Rationale

To deliver primary prevention of CVD requires that patients at risk are identified before disease has become established and that requires screening.

Current NICE Guidance (May 2008) recommends that the Framingham 1991¹⁰ 10 year risk equations should be used to assess CVD risk. The variables required for this estimation are:

- Age
- Sex
- Systolic blood pressure (mean of previous two systolic readings)
- Total cholesterol
- HDL cholesterol
- Smoking status
- Presence of left ventricular hypertrophy

Key to this assessment however, is that it should be an assessment of **actual** as opposed to estimated risk. The values used should have been recorded no longer than 6 months before the date of the risk assessment and prior to any treatment for hypertension.

This risk equation should not be used for people with:

- Coronary Heart Disease or angina
- Stroke or TIA
- Peripheral vascular disease
- Familial hypercholesterolemia
- Diabetes
- Chronic Kidney Disease

Further information: *Lipid Modification: Cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease*. Clinical Guideline 67. NICE: London 2008

¹⁰ NICE CG67, Appendix H (p.41)

<http://www.nice.org.uk/nicemedia/pdf/CG67FullGuidelineAppendixEFGHIJ.pdf>

Original ref: Anderson KM, Odell PM, Wilson PW et al. (1991) Cardiovascular disease risk profiles. American Heart Journal 121: 293-8. Risk profile only:

<http://www.framinghamheartstudy.org/risk/coronary.html>

<http://www.nice.org.uk/nicemedia/pdf/CG067NICEGuideline.pdf>

It would be inappropriate to use the risk score for those patients already taking lipid lowering medication prior to a new diagnosis of hypertension.

The ASSIGN cardiovascular risk score was developed as part of the SIGN 97 process to reduce the deprivation-related underestimation of CVD risk inherent in previous Framingham based risk scores for Scottish populations. (see www.assign-score.com) and continues to be developed. It is available through a web link to practices in Scotland and encompasses deprivation related risk due to post code.

Scottish practices should use the ASSIGN risk score or the Framingham 1991 10 year risk equations for the purposes of this indicator.

Primary prevention 1.2 Reporting and verification

The practices reports the number of patients with a new diagnosis of hypertension (excluding those with a pre-existing diagnosis of CHD, diabetes, stroke and/or TIA) in the preceding 1 April to 31 March and the percentage of these patients who have had a face to face CVD risk assessment within 3 months before and after the date of diagnosis using an agreed risk assessment tool.

Verification – PCOs may randomly select a number of case records of patients in which a risk assessment has been recorded as taking place to confirm that the key risk factors have been addressed and that biochemical and other clinical data used to inform the risk assessment are up-to-date.

Primary prevention (PP) Indicator 2

The percentage of people diagnosed with hypertension diagnosed after 1 April 2009 who are given lifestyle advice in the last 15 months for: increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet.

Primary prevention 2.1 Rationale

There is considerable evidence to support the positive impact of increasing physical activity, smoking cessation, reducing unsafe alcohol consumption, and improving diet on cardiovascular health.

Patients with hypertension are at increased risk of developing CVD and this risk can be reduced, not only by treating their hypertension, but by also reducing lifestyle risks.

Practices should refer to recognised guidance and advice on advising patients on lifestyle risk.

Further information:

Smoking Cessation: guidance and recent developments in smoking cessation in Smoking Cessation Update 2007- (NHS Health Scotland and ASH Scotland).

<http://www.healthscotland.com/documents/1762.aspx>

Alcohol SIGN Guideline 74

<http://www.sign.ac.uk/guidelines/fulltext/74/index.html>

Plan for Action on Alcohol Problems Update Scottish Government 2008

<http://www.scotland.gov.uk/Publications/2007/02/19150222/12>

Diet and physical activity

Healthy Eating, Active Living: An action plan to improve diet, increase physical activity and tackle obesity (2008-2011) Scottish Government 2008

<http://www.scotland.gov.uk/Publications/2008/06/20155902/10>

Further information on the management of lifestyle factors can be found in *Lipid Modification: Cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease*. Clinical Guideline 67. NICE: London 2008

This advice should be reiterated on an annual basis.

Primary prevention (PP) 2.2 Reporting and verification

Practices should report the percentage of people diagnosed with hypertension on or after 1 April 2009 who have been given lifestyle advice in the previous 15 months for: increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet.

Verification - PCOs may randomly select a number of case records of patients in which this advice has been recorded as taking place to confirm that the four key issues are recorded as having been addressed, if applicable.

Heart Failure

Indicator	Points	Payment stages
Records		
HF1: The practice can produce a register of patients with heart failure	4	
Initial diagnosis		
HF2: The percentage of patients with a diagnosis of heart failure (diagnosed after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment	6	40-90%
Ongoing management		
HF3: The percentage of patients with a current diagnosis of heart failure due to Left Ventricular Dysfunction (LVD) who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker (ARB), who can tolerate therapy and for whom there is no contra-indication	10	40-80%
HF4: The percentage of patients with a current diagnosis of heart failure due to LVD who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker, who are additionally treated with a beta-blocker licensed for heart failure, or recorded as intolerant to or having a contraindication to beta-blockers	9	40-60%

Heart Failure- Rationale for Inclusion of Indicator Set

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

Heart Failure (HF) Indicator 1

The practice can produce a register of patients with heart failure.

Heart Failure 1.1 Rationale

From April 2006, all patients with heart failure should be included in the register.

Heart Failure 1.2 Reporting and Verification

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

Heart Failure (HF) Indicator 2

The percentage of patients with a diagnosis of heart failure (diagnosed after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment

Heart Failure 2.1: Rationale

From April 2006, all patients with suspected heart failure should be investigated¹¹ (Senni et al. *J Am Coll Cardiol.* 1999; 33(1): 164 – 70; NICE clinical guideline 5. National Institute for Health and Clinical Excellence, London: 2003) and this is expected to involve, as a minimum, specialist investigation (such as echocardiography or natriuretic peptide assay) and often specialist opinion. Specialists may include GPs identified by their PCO as having a special clinical interest in heart failure. Many heart failure patients will be diagnosed following specialist referral or during hospital admission and some will also have their diagnosis confirmed by tests such as cardiac scintigraphy or angiography rather than echocardiography. Current guidance¹² (Remme et al. *Eur Heart J* 2001; 22: 1527-60) requires either echocardiography or specialist assessment for all patients with suspected heart failure, regardless of presumed aetiology.

Further information:

<http://www.nice.org.uk/http://www.nice.org.uk/nicemedia/pdf/CG5NICEguideline.pdf>

Heart Failure 2.2 Reporting and Verification

The practice reports those patients in whom a new diagnosis of heart failure has been made since 1 April 2006 who have had an echocardiogram or been referred to a specialist within 12 months of being added to the register. The practice may also include patients who have been referred up to three months before being added to the register.

Heart Failure (HF) Indicator 3

The percentage of patients with a current diagnosis of heart failure due to Left Ventricular Dysfunction (LVD) who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker (ARB), who can tolerate therapy and for whom there is no contraindication

Heart Failure 3.1 Rationale

The evidence base for treating patients with LVD heart failure with ARBs is strong, however, this should only be after first attempting to initiate ACE inhibitors (Pfeffer et al. *Lancet* 2003; 362: 759-766).

It should also be noted that it is possible to have a diagnosis of LVD without heart failure, for example, asymptomatic people who might be identified coincidentally but who are at high risk of developing subsequent heart failure. In such cases ACE inhibitors delay the onset of symptomatic heart failure, reduce cardiovascular events and improve long-term survival. This indicator only concerns patients with heart failure and thus excludes this other group of patients who should nevertheless be considered for treatment with ACE inhibitors¹³.

¹¹ Senni et al. *J Am Coll Cardiol.* 1999; 33(1): 164-70; NICE *clinical guideline* 5. National Institute for Health and Clinical Excellence, London:2003.

¹² Remme et al. *Eur Heart J* 2001 ; 22 : 1527-60

¹³ Pfeffer et al. *Lancet* 2003; 362: 759-766

Further information:

www.clinicalevidence.com/ceweb/conditions/cvd/0204/0204_I13.jsp

<http://www.sign.ac.uk/guidelines/fulltext/95/index.html>

Heart Failure 3.2 Reporting and Verification.

Practices report the number of patients on their heart failure register with heart failure due to LVD.

Practices report the percentage of these patients whose records show they have been prescribed an ACE inhibitor or an ARB in the previous six months.

Heart failure (HF) indicator 4

The percentage of patients with a current diagnosis of heart failure due to LVD who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker, who are additionally treated with a beta-blocker licensed for heart failure, or recorded as intolerant to or having a contraindication to beta-blockers.

Heart failure 4.1 Rationale

The evidence base for treating heart failure due to LVD with beta-blockers^{14 15} is at least as strong as the evidence base guiding the HF 3 indicator on ACE inhibitors (Level Ia), with a 34% reduction in major endpoints of beta-blockers on top of ACE inhibitors compared to placebo, and is a standard recommendation in all heart failure guidelines including NICE. The belief that beta-blockers are contra-indicated in heart failure was disproved, at least for the licensed betablockers, in the late 1990s and in some countries (especially Scandinavia) betablockers have never been contraindicated in heart failure. Furthermore, there are no data to suggest excess risk in the elderly (SENIORS with nebivolol only randomised people over 75 with significant benefits and no safety signal) and there are no contra-indication for use in people with COPD.

However, this strategy is more difficult in clinical practice than initiating ACE (more contra-indications, less tolerated, with a need for slower but more dose titration steps. Furthermore, there are negative trials of beta-blockers in heart failure¹⁶ and concerns over the effectiveness of atenolol in reducing vascular risk generally. Therefore the beta blocker used should be one licensed for heart failure, which is also in line with NICE recommendations. The only such agents in the UK are carvedilol, bisoprolol and nebivolol.

However, despite the evidence above, initiating beta-blockers in heart failure, or switching from one not licensed for heart failure, is more difficult because of the need

¹⁴ Deedwania PC, Giles TD, Klibaner M, Ghali JK, Herlitz J, Hildebrandt P, Kjekshus J, Spinar J, Vitovec J, Stanbrook H, Wikstrand J; MERIT-HF Study Group. Efficacy, safety and tolerability of metoprolol CR/XL in patients with diabetes and chronic heart failure: experiences from MERIT-HF. *Am Heart J*. 2005; 49 (1):159-67.

¹⁵ CIBIS-II Investigators and Committees. The Cardiac Insufficiency Bisoprolol Study II. *Lancet* 1999; 353: 9-13.

¹⁶ [Anderson JL, Krause-Steinrauf H, Goldman S, Clemson BS, Domanski MJ, Hager WD, Murray DR, Mann DL, Massie BM, McNamara DM, Oren R, Rogers WJ; Beta-Blocker Evaluation of Survival Trial \(BEST\) Investigators.](#) Failure of benefit and early hazard of bucindolol for Class IV heart failure. *J Card Fail*. 2003; 9 (4): 266-77

to titrate from low doses and small increments over repeated visits. Patients also often suffer a temporary deterioration in symptoms with beta-blocker initiation which needs monitoring. The British National Formulary states that ‘beta-blockers bisoprolol and carvedilol are of value in any grade of stable heart failure and left-ventricular systolic dysfunction; nebivolol is licensed for stable mild to moderate heart failure. Beta-blocker treatment should be started by those experienced in the management of heart failure, at a very low dose and titrated very slowly over a period of weeks or months. Symptoms may deteriorate initially, calling for adjustment of concomitant therapy’¹⁷.

Heart failure 4.2 Reporting and verification

The practice reports the percentage of patients with a current diagnosis of heart failure due to LVD who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker, who are additionally treated with a beta-blocker licensed for heart failure, or recorded as intolerant to or having a contraindication to beta-blockers

¹⁷ <http://www.bnf.org/bnf/bnf/current/119651.htm> (password protected site)

Stroke and Transient Ischaemic Attack (TIA)

Indicator	Points	Payment Stages
Records		
STROKE 1. The practice can produce a register of patients with stroke or TIA	2	
STROKE 13. The percentage of new patients with a stroke or TIA who have been referred for further investigation	2	40-80%
Ongoing Management		
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	40-90%
STROKE 6. The percentage of patients with a history of TIA or stroke in whom the last blood pressure reading (measured in the previous 15 months) is 150/90 or less	5	40-70%
STROKE 7. The percentage of patients with TIA or stroke who have a record of total cholesterol in the last 15 months	2	40-90%
STROKE 8. The percentage of patients with TIA or stroke whose last measured total cholesterol (measured in the previous 15 months) is 5 mmol/l or less	5	40-60%
STROKE 12. The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record that an anti-platelet agent (aspirin, clopidogrel, dipyridamole or a combination), or an anti-coagulant is being taken (unless a contraindication or side-effects are recorded)	4	40-90%
STROKE 10. The percentage of patients with TIA or stroke who have had influenza immunisation in the preceding 1 September to 31 March	2	40-85%

Stroke/TIA - Rationale for Inclusion of Indicator Set

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

Stroke Indicator 1

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

Stroke 1.1 Rationale

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

For patients diagnosed prior to April 2003 it is accepted that various diagnostic criteria may have been used. For this reason the presence of the diagnosis of stroke or TIA in the records will be acceptable. Generally patients with a diagnosis of Transient Global Amnesia or Vertebro-basilar insufficiency should not be included in the

retrospective register. However, practices may wish to review patients previously diagnosed and if appropriate attempt to confirm the diagnosis.

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

Stroke 1.2 Reporting and Verification

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

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

Stroke Indicator 13

The percentage of new patients with a stroke or TIA who have been referred for further investigation

Stroke 13.1 Rationale

The original indicator, stroke 2 suggested that patients needed to be referred for confirmation of the diagnosis by CT or MRI scan. However specialist investigations are often only accessible by a referral to secondary care services and therefore this indicator has been changed to reflect referral activity rather than confirmation by specific scanning investigations.

The NAO report (Reducing brain damage: faster access to better stroke care. London; The Stationary Office 2005) highlights that UK national guidelines recommend that all patients with suspected TIA should be assessed and investigated within seven days, but notes that only a third of people with TIA are seen in a clinic. The UK Guideline and the NAO concern reflect the evidence that there is a high early risk of stroke following TIA, and that there is insufficient recognition of the serious nature of this diagnosis.

This indicator refers to patients diagnosed with a stroke or a TIA from 1 April 2008. Practices should note that a referral should be considered for each new stroke or TIA unless specific agreement has been reached with a local specialist not to refer the patient. A new TIA in someone who has had previous TIAs should be treated as an urgent case.

For the purposes of the QOF, an appropriate referral being undertaken between three months before and one month after a diagnosis of presumptive stroke or TIA being made would be considered as having met the requirements of this indicator.

Stroke 13.2 Reporting and Verification

The practice should report those patients who have been referred for further investigation within one month of being added to the register in whom a new diagnosis of stroke or TIA has been made since 1 April 2008. The practice should also report those who have been referred up to three months before being added to the register.

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

- i. Inspection of the output from a computer search that has been used to provide information on this indicator.
- ii. Inspection of a sample of records of patients with stroke or TIA diagnosed after 1 April 2008 to look at the proportion referred for further investigation.
- iii. Inspection of a sample of records of patients for whom a record of investigations such as CT or MRI scan is claimed, to see if there is evidence of this in the medical records.

Stroke Indicator 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 two weeks should be treated. The British Hypertension Society Guidelines state that optimal blood pressure treatment targets are systolic pressure less than or equal to 140 mm Hg and diastolic blood pressure (DBP) less than or equal to 85 mm Hg. 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 approximately 35-40 per cent less stroke over five years. (Collins et al. Lancet 1990; 335: 827-38). The PROGRESS trial demonstrated that blood pressure lowering reduces stroke risk in people with prior stroke or TIA. (PROGRESS Collaborative Group, Lancet 2001; 358:1033-41).

Grade A Recommendation RCP Stroke Guideline 2004

Further Information:

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 their 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 the previous 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 was 150/90 or less. This blood pressure reading should have been taken in the previous 15 months.

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

The Heart Protection Study demonstrated that all cause mortality, vascular and stroke risk was significantly reduced by treating people at high risk of vascular disease with a statin (Heart Protection Study Collaborative Group, Lancet 2002; 360:7-22).

Subsequent sub-group analyses demonstrated that in patients with prior stroke or TIA, statin therapy reduced risk of subsequent vascular events (Heart Protection Study Collaborative Group, Lancet 2004; 363:757-767). An economic analysis of this trial concluded that it was highly cost-effective to treat such patients (Heart Protection Study Collaborative Group, Lancet 2005; 365:1779-85).

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 previous 15 months.

In verifying that this information has been correctly recorded the following approach could be taken by a PCO:

- i. Inspection of the output from a computer search that has been used to provide information on this indicator

Stroke Indicator 8

The percentage of patients with TIA or stroke whose last measured total cholesterol (measured in the previous 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 previous 15 months which is 5mmol/l or less.

In verifying that this information has been correctly recorded the following approach could be taken by a PCO:

- i. Inspection of the output from a computer search that has been used to provide information on this indicator

Stroke Indicator 12

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

Stroke 12.1 Rationale

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

Grade A recommendation SIGN 13

Further information: <http://www.sign.ac.uk/pdf/sign13.pdf>
<http://www.sign.ac.uk/guidelines/fulltext/108/index.html>

All patients who are not anti-coagulated 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:

The National Clinical Guideline for Stroke (Royal College of Physicians of London, 2004) now allows for the use of dipyridamole on its own: 'all patients with ischaemic stroke or TIA who are not on anticoagulation, should be taking an antiplatelet agent, i.e. aspirin (50-300mg daily), clopidogrel, or a combination of low-dose aspirin and dipyridamole modified release. Where patients are aspirin intolerant an alternative antiplatelet agent (e.g. clopidogrel 75mg daily or dipyridamole MR 200mg twice daily) should be used.'

www.rcplondon.ac.uk/pubs/books/stroke/stroke_guidelines_2ed.pdf

Warfarin should be considered for use in patients with non-valvular atrial fibrillation.
Grade A recommendation SIGN 108

Stroke 12.2 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, dipyridamole MR 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

While there have been no randomised controlled trials (RCTs) looking at the impact of flu vaccination specifically in people with a history of stroke or TIA, there is evidence from observation studies that flu vaccination reduces risk of stroke (Lavalley et al. Stroke 2002; 33: 513-518; Nichol et al. NEJM 2003; 348:1322-32). This is now included in JCVI recommendations.

Stroke 10.2 Reporting and Verification

Practices should report 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
Records		
BP 1. The practice can produce a register of patients with established hypertension	6	
Ongoing Management		
BP 4. The percentage of patients with hypertension in whom there is a record of the blood pressure in the previous 9 months	18	40-90%
BP 5. The percentage of patients with hypertension in whom the last blood pressure (measured in the previous 9 months) is 150/90 or less	57	40-70%

Hypertension - Rationale for Inclusion of Indicator Set

Hypertension is a common medical condition which is largely managed in primary care and represents a significant workload for GPs and the primary health care team. Trials of anti-hypertensive treatment have confirmed a significant reduction in the incidence of stroke and 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 160 mmHg or sustained diastolic blood pressures of greater than or equal to 100 mmHg despite non-pharmacological measures.

Drug treatment is also indicated in patients with sustained systolic blood pressures of 140-159 mmHg or diastolic pressures of 90-99 mmHg if target organ damage is present or there is evidence of established 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 2004

Further information: www.bhsoc.org (see guidelines)

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 4

The percentage of patients with hypertension in whom there is a record of the blood pressure in the previous nine months

BP 4.1 Rationale

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

British Hypertension Society Guidelines 2004

Further information: www.bhsoc.org

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 measurement recorded in the previous nine months.

Hypertension (BP) Indicator 5

The percentage of patients with hypertension in whom the last blood pressure (measured in the previous 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 QOF. For patients with diabetes mellitus, see DM12. For patients with chronic kidney disease, see CKD4.

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. This blood pressure reading must have been measured in the previous nine months.

Diabetes Mellitus

Indicator	Points	Payment Stages
Records		
DM 19. The practice can produce a register of all patients aged 17 years and over with diabetes mellitus, which specifies whether the patient has Type 1 or Type 2 diabetes	6	
Ongoing Management		
DM 2. The percentage of patients with diabetes whose notes record BMI in the previous 15 months	3	40-90%
DM 5. The percentage of patients with diabetes who have a record of HbA1c or equivalent in the previous 15 months	3	40-90%
DM 23. The percentage of patients with diabetes in whom the last HbA1c is 7 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months	17	40-50%
DM 24. The percentage of patients with diabetes in whom the last HbA1c is 8 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months	8	40-70%
DM 25. The percentage of patients with diabetes in whom the last HbA1c is 9 or less (or equivalent test/reference range depending on local laboratory) in previous 15 months	10	40-90%
DM 21. The percentage of patients with diabetes who have a record of retinal screening in the previous 15 months	5	40-90%
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	40-90%
DM 10. The percentage of patients with diabetes with a record of neuropathy testing in the previous 15 months	3	40-90%
DM 11. The percentage of patients with diabetes who have a record of the blood pressure in the previous 15 months	3	40-90%
DM 12. The percentage of patients with diabetes in whom the last blood pressure is 145/85 or less	18	40-60%
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	40-90%
DM 22. The percentage of patients with diabetes who have a record of estimated glomerular filtration rate (eGFR) or serum creatinine testing in the previous 15 months	3	40-90%
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	40-80%
DM 16. The percentage of patients with diabetes who have a record of total cholesterol in the previous 15 months	3	40-90%
DM 17. The percentage of patients with diabetes whose last measured total cholesterol within the previous 15 months is 5 mmol/l or less	6	40-70%

DM 18. The percentage of patients with diabetes who have had influenza immunisation in the preceding 1 September to 31 March	3	40-85%
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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) and by SIGN - the Scottish Intercollegiate Guidelines Network (see 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

www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Diabetes/fs/en 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).

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

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

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

Diabetes (DM) Indicator 19

The practice can produce a register of all patients aged 17 years and over with diabetes mellitus, which specifies whether the patient has Type 1 or Type 2 diabetes

DM 19.1 Rationale

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

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

The World Health Organisation (WHO) 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 (usually overnight) and on two different days is also a diagnosis of diabetes.
- **glucose tolerance test:** a blood glucose test is taken two hours after a glucose drink is given to the patient. A level above 11.1mmol/l is a diagnosis of diabetes, while a level below 7.8 is normal. However, if the level falls between these values the patient may have a decreased tolerance for glucose (known as impaired glucose tolerance or IGT).

Distinguishing Type 1 and Type 2 diabetes clinically may not always be easy in primary care. If this is unclear from the patient's paper or electronic records, the code for Type 1 diabetes should be used if the person is diagnosed with diabetes before the age of 30 or requires insulin within 1 year of diagnosis, and otherwise, the code for Type 2 should be used.

Separate coding of Type 1 and Type 2 diabetes allows the development of QOF indicators that are more closely aligned to NICE guidance.

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

DM 19.2 Reporting and Verification

Practices should separately report the numbers of patients on their diabetic register (age 17 and over) with Type 1 and Type 2 diabetes and the number of patients on their diabetic register (age 17 and over) with Type 1 and Type 2 diabetes as a proportion of their total list size.

Practices should note that there has been a change to the acceptable read codes for this indicator to reflect the need for all patients to be recorded as having either Type 1 or Type 2 diabetes.

Verification – in order to ensure that patients with diabetes are not 'lost' due to the change in read codes, PCOs may wish to compare reported practice prevalence not

only with national prevalence but with the practice prevalence for 04/05.

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 Indicator (DM) 5

The percentage of patients with diabetes 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.

NICE Guidance for Type 2 diabetes 2008 - <http://www.nice.org.uk/Guidance/CG66>

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

There are proposals to modify the reporting of HbA1c during 2009-2010, so that results are also reported in mmol/mol. However laboratories will continue to report using the current percentage figure until April 2011. The QOF criteria for 2009-2010 are therefore based on the current arrangements to report HbA1c as a percentage figure.

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 PCO:

- i. Inspection of the output from a computer search that has been used to provide information on this indicator.
- ii. Inspection of a sample of records of patients with diabetes to look at the proportion with recorded HbA1c in last 15 months.
- iii. 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 23

The percentage of patients with diabetes in whom the last HbA_{1c} is 7 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months.

Diabetes 23.1 Rationale

The relationship between hyperglycaemia and cardiovascular risk is essentially linear, so for those with raised HbA_{1c} levels, better glycaemic control should lead to reduced cardiac risk. For people with Type 1 diabetes, the finding of a 42% reduction in cardiovascular events in those treated intensively in the DCCT trial provides evidence for this (DCCT/EDICT, 2005). Similarly, 10 year follow-up data from the UKPDS trial showed significantly less cardiovascular disease in those patients with Type 2 diabetes who were intensively treated (Holman et al, 2008).

The three target levels for HbA_{1c} (7%, 8% and 9%) are designed to provide an incentive to improve glycaemic control across the distribution of HbA_{1c} values. The lower level may not be achievable for all patients, but the payment thresholds reflect this. Also practitioners should note that in the 2008 guidance for Type 2 diabetes NICE advises against pursuing highly intensive management to levels below 6.5%.

NICE Guidance for Type 2 diabetes 2008: <http://www.nice.org.uk/Guidance/CG66>

NICE identifies the following key priorities to help people with Type 2 diabetes achieve better glycaemic control:

- Offer structured education to every person and/or their carer at and around the time of diagnosis, with annual reinforcement and review. Inform people and their carers that structured education is an integral part of diabetes care.
- Provide individualised and ongoing nutritional advice from a healthcare professional with specific expertise and competencies in nutrition.
- When setting a target glycated haemoglobin:
 - involve the person in decisions about their individual HbA_{1c} target level, which may be above that of 6.5 % set for people with Type 2 diabetes in general
 - encourage the person to maintain their individual target unless the resulting side effects (including hypoglycaemia) or their efforts to achieve this impair their quality of life
 - offer therapy (lifestyle and medication) to help achieve and maintain the HbA_{1c} target level
 - inform a person with a higher HbA_{1c} that any reduction in HbA_{1c} towards the agreed target is advantageous to future health
 - avoid pursuing highly intensive management to levels of less than 6.5 %.

- Offer self-monitoring of plasma glucose to a person newly diagnosed with Type 2 diabetes only as an integral part of his or her self-management education. Discuss its purpose and agree how it should be interpreted and acted upon.
- When starting insulin therapy, use a structured programme employing active insulin dose titration that encompasses: *structured education, continuing telephone support, frequent self-monitoring, dose titration to target, dietary understanding, management of hypoglycaemia, management of acute changes in plasma glucose control, support from an appropriately trained and experienced healthcare professional.*
- References¹⁸

¹⁸ References:

Holman RR, Paul SK, Bethel MA, Matthews DR, Neil HA. 10-Year Follow-up of Intensive Glucose Control in Type 2 Diabetes. The New England Journal of Medicine 2008; 359(15):1577-1589.

DCCT/EDIC Study Research Group. Intensive Diabetes Treatment and Cardiovascular Disease in Patients with Type 1 Diabetes. The New England Journal of Medicine 2005; 353(25):2643-2653

Diabetes 23.2 Reporting and verification

The practice should report the percentage of patients on the diabetic register in which the last HbA1c measurement was 7 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 PCO:

- i. Inspection of the output from a computer search that has been used to provide information on this indicator.
- ii. Inspection of a sample of record of patients with diabetes to look at the proportion with last recorded HbA1c 7 or less.
- iii. Inspection of a sample of records of patients for whom a record of HbA1c 7 or less is claimed, to see if there is evidence of this in the medical records.

Diabetes (DM) indicator 24

The percentage of patients with diabetes in whom the last HbA1c is 8 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months

Diabetes 24.1 Rationale

See DM 23.1 above. Auditing the proportion of patients with an HbA1c below 8% is designed to provide an incentive to improve glycaemic control across the range of HbA1c values.

Diabetes 24.2 Reporting and verification

The practice should report the percentage of patients on the diabetic register in which the last HbA1c measurement was 8 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 PCO:

- i. Inspection of the output from a computer search that has been used to provide information on this indicator.
- ii. Inspection of a sample of record of patients with diabetes to look at the proportion with last recorded HbA1c 8 or less.
- iii. Inspection of a sample of records of patients for whom a record of HbA1c 8 or less is claimed, to see if there is evidence of this in the medical records.

Diabetes (DM) indicator 25

The percentage of patients with diabetes in whom the last HbA1c is 9 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months.

Diabetes 25.1 Rationale

See DM 23.1 above. Auditing the proportion of patients with an HbA1c below 9% is designed to provide an incentive to improve glycaemic control amongst those with high levels of HbA1c who are at particular risk. The target level has been reduced in order to provide an incentive to improve the care of more people with high levels of HbA1c.

Diabetes 25.2 Reporting and verification

The practice should report the percentage of patients on the diabetic register in which the last HbA1c measurement was 9 or less. The test must have been carried out in the previous 15 months.

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

- i. Inspection of the output from a computer search that has been used to provide information on this indicator.
- ii. Inspection of a sample of records of patients with diabetes to look at the proportion with last recorded HbA1c 9 or less.
- iii. Inspection of a sample of records of patients for whom a record of HbA1c 9 or less is claimed, to see if there is evidence of this in the medical records.

Diabetes (DM) Indicator 21

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

DM 21.1 Rationale

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

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 local services meet those standards) or PCO standards otherwise.

In Scotland, the local Diabetic Retinopathy Screening (DRS) service provided under the auspices of the Scottish DRS Programme, is the “approved retinal screening

service” (HDL May 2006)

DM 21.2 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. To meet this indicator practices must now demonstrate that patients have received retinal screening to the required standard.

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.

Foot risk stratification

Although absent pulses and neuropathy are risk factors for foot ulceration, there are other factors which are better predictors, e.g. previous ulceration. Also the presence of these conditions does not direct the clinician towards what to do practically. As a result foot risk stratification programmes have been introduced across Scotland and in many areas in England and Wales. Foot risk scores integrate a few of the best simple clinical predictors of foot ulceration (including pulses, neuropathy, previous ulceration and foot deformity), so that patients are categorized into high, moderate and low risk categories, which then directly relate to the care that is recommended for that patient.

Further information: NICE guidelines (2002). Type-2 diabetes. Prevention and management of foot problems. Section 6. Foot care management for people with diabetes: recommendations (p45).

www.nice.org.uk/nicemedia/pdf/CG10fullguideline.pdf

International Working Group for the Diabetic Foot :Guidelines on screening (2007)

www.iwgdf.org/index.php?option=com_content&task=view&id=39&Itemid=60

Diabetes Action Plan (Scottish Diabetes Framework). Scottish Executive 2006.

<http://www.scotland.gov.uk/Resource/Doc/129328/0030795.pdf>

SIGN guideline 55 (2001) Management of Diabetes

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

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.

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

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 previous 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 their blood pressure recorded in the previous 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

The most commonly identified target level for blood pressure in patients with diabetes is 140/80. This is the level that health professionals 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>

Guidelines for management of hypertension: report of the fourth working party of the British Hypertension Society, 2004 BHS IV

Journal of Human Hypertension 2004, 18(3), 139-185

www.bhsoc.org/Latest_BHS_management_Guidelines.stm

NICE inherited guideline H

<http://www.nice.org.uk/guidance/index.jsp?action=byID&r=true&o=10913>

www.nice.org.uk/page.aspx?o=38551

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 previous 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. Urinary microalbuminuria has been identified as an independent risk factor for cardiovascular complications. Its presence is therefore a pointer to the need for more rigorous management of all cardiovascular risk factors. All patients with 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:

www.sign.ac.uk/guidelines/fulltext/55/index.html

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

Health Technology Assessment Review 2005

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 22

The percentage of patients with diabetes who have a record of estimated glomerular filtration rate (eGFR) or serum creatinine testing in the previous 15 months

DM 22.1 Rationale

See DM 13.1

Estimated glomerular filtration rate (eGFR), based on serum creatinine is reported as a better means to detect and monitor early renal disease and will be routinely reported data in 2006. This has therefore now been included in indicator 22. In the long term, eGFR should be easier for patients to understand, as log transformation is not required to assess change in renal function.

DM 22.2 Reporting and Verification

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

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

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

Diabetes (DM) Indicator 15

The percentage of patients with diabetes with a diagnosis of proteinuria or 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 British National Formulary (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 the 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 55

Further Information: <http://www.sign.ac.uk/guidelines/fulltext/55/section4.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 patients with diabetes 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 diabetes register who have had a total cholesterol measured 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:

- i. Inspection of the output from a computer search that has been used to provide

information on this indicator.

- ii. Inspection of a sample of records of patients with diabetes to look at the proportion with recorded serum cholesterol.
- iii. 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 the prescription of a statin should be considered for all diabetic patients over the age of 40, particularly if their cholesterol is greater than 5mmol/l. 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.

Further Information:

Heart Protection Study Collaborative Group: MRC/BHF Heart Protection Study of cholesterol-lowering with simvastatin in 5963 people with diabetes: a randomised placebo-controlled trial. *Lancet* 2003; 361:2005-2016.

Mortality from Coronary Heart Disease in Subjects with Type 2 Diabetes and in Nondiabetic Subjects with and without Prior Myocardial Infarction Haffner et al. *NEJM* 1998; 339: 229-234.

SIGN Guideline 97: Risk estimation and the prevention of cardiovascular disease
<http://www.sign.ac.uk/guidelines/fulltext/97/index.html>

DM 17.2 Reporting and Verification

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

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

- i. Inspection of the output from a computer search that has been used to provide information on this indicator.
- ii. Inspection of a sample of records of patients with diabetes to look at the proportion with recorded serum cholesterol less than 5 mmol/l.
- iii. 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.

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
Records		
COPD 1. The practice can produce a register of patients with COPD	3	
Initial diagnosis		
COPD 12. The percentage of all patients with COPD diagnosed after 1 st April 2008 in whom the diagnosis has been confirmed by post broncholidator spirometry	5	40-80%
Ongoing management		
COPD 10. The percentage of patients with COPD with a record of FeV1 in the previous 15 months	7	40-70%
COPD 13. The percentage of patients with COPD who have had a review,undertaken by a healthcare professional,including an assessment of breathlessness using the MRC dyspnoea score in the preceding 15 months. in the preceding 15 months	9	50-90%
COPD 8. The percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March	6	40-85%

COPD - Rationale for Inclusion of Indicator Set

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. 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 post bronchodilator spirometry.

See COPD 12.1.

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

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.

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

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

COPD Indicator 12

The percentage of all patients with COPD diagnosed after 1st April 2008 in whom the diagnosis has been confirmed by post bronchodilator spirometry.

COPD 12.1 Rationale

COPD is diagnosed if:

- the patient has an FeV1 of less than 80 per cent of predicted normal
- and has an FeV1/FVC ratio of less than 70 per cent
- and the patient has symptoms consistent with COPD.

Spirometry should be performed after the administration of an adequate dose of an inhaled bronchodilator (e.g. 400mcg salbutamol)

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

All of these elements are required to make the diagnosis of COPD. Routine reversibility testing is not recommended in NICE, and the GOLD guidelines require post bronchodilator spirometry for diagnosis and grading. Failure to use post bronchodilator readings overestimate the prevalence of COPD by 25% (Johannessen et al. Thorax 2005; 60(10): 842-847). This change will reduce workload in primary care and removes the conflict with evidence based guidelines.

Where doubt occurs as to whether the diagnosis is asthma or COPD, reversibility testing may add additional information to post bronchodilator readings alone and peak flow charts are useful. It is acknowledged that COPD and asthma can co-exist and that many patients with asthma who smoke will eventually develop irreversible airways obstruction. However, where asthma is present, these patients should be

managed as asthma patients as well as COPD patients. This will be evidenced by a greater than 400mls response to a reversibility test and a post bronchodilator FeV1 of <80% of predicted normal as well as an appropriate medical history.

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

Further information:

Global Strategy for the Diagnosis, Management and Prevention of COPD 2006

www.goldcopd.org

NICE Clinical Guideline 2004

www.nice.org.uk/guidance/index.jsp?action=download&o=29303

http://thorax.bmj.com/content/vol59/suppl_1/

For the purposes of the QOF, post bronchodilator spirometry undertaken between three months before and twelve months after a diagnosis of COPD being made would be considered as meeting the requirements of this indicator.

COPD 12.2 Reporting and Verification

Practices should report the percentage of patients diagnosed after 1st April 2008 who are on their COPD register, who have a record that the diagnosis has been confirmed by post bronchodilator spirometry.

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

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

COPD Indicator 10

The percentage of patients with COPD with a record of FeV1 in the previous 15 months

COPD 10.1 Rationale

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

Current guidance states that there are no clear guidelines with regard to the optimum frequency of spirometry for patients with COPD and the time interval was pragmatically set at two years. However NICE Clinical Guideline 12 (February 2004), endorsed by the British Thoracic Society, now suggests that FeV1 and inhaler technique should be assessed at least annually for people with mild/moderate COPD (and in fact at least twice a year for people with severe COPD). The purpose of regular monitoring is to identify patients with increasing severity of disease who may benefit from referral for more intensive treatments/diagnostic review.

Further information:

Table 7 in http://thorax.bmj.com/content/vol59/suppl_1/

The QOF 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 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 September 2004

<http://www.goldcopd.com/>

Referral can be to a general physician, a respiratory physician or a GP with a special interest (GPwSI) in respiratory disease. It is suggested that consideration for referral should be given in patients with FeV1 of less than 50 per cent predicted or in patients with disabling symptoms.

COPD 10.2 Reporting and Verification

Practices should report the percentage of patients on the COPD register who have had spirometry performed in the previous 15 months.

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

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

COPD indicator 13

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

COPD 13.1 Rationale

COPD is increasingly recognised as a treatable disease with large improvements in symptoms, health status, exacerbation rates and even mortality if managed appropriately. Appropriate management should be based on NICE guideline CG12 and international GOLD guidelines in terms of both drug and non-drug therapy.

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

- current lung function,
- exacerbation history,
- degree of breathlessness (MRC dyspnoea scale) and

A tool such as the Clinical COPD Questionnaire could be used to assess current health status

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

The MRC dyspnoea scale gives a measure of breathlessness and is recommended as part of the regular review. It is available through the link below, under Diagnosing COPD, table 3.

www.thorax.bmj.com/content/vol59/suppl_1/

Further information on management of COPD:

www.thorax.bmj.com/content/vol59/suppl_1/

<http://www.nice.org.uk/Guidance/CG12>

<http://www.goldcopd.com>

www.ccq.nl

COPD 13.2 Reporting and verification

The practice should report the percentage of patients on the COPD register who have had a review of their COPD by a healthcare professional which included an assessment of breathlessness using the MRC dyspnoea score in the preceding 15 months.

Verification - PCOs may randomly select a number of case records of patients in which the review has been recorded as taking place to confirm that the defined elements are recorded as having been addressed, if applicable.

COPD Indicator 8

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

COPD 8.1 Rationale

This is a current recommendation from the Departments of Health and the Joint Committee on Vaccination and Immunisation.

COPD 8.2 Reporting and Verification

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

Epilepsy

Indicator	Points	Payment Stages
Records		
EPILEPSY 5. The practice can produce a register of patients aged 18 and over receiving drug treatment for epilepsy	1	
Ongoing Management		
EPILEPSY 6. The percentage of patients age 18 and over on drug treatment for epilepsy who have a record of seizure frequency in the previous 15 months	4	40-90%
EPILEPSY 7. The percentage of patients age 18 and over on drug treatment for epilepsy who have a record of medication review involving the patient and/or carer in the previous 15 months	4	40-90%
EPILEPSY 8. The percentage of patients age 18 and over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the previous 15 months	6	40-70%

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. For the purposes of the QOF, epilepsy is defined as 'recurrent unprovoked seizures.'

Epilepsy Indicator 5

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

Epilepsy 5.1 Rationale

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

It is proposed that the disease register includes patients aged 18 and over as care for younger patients is generally undertaken outside of primary care.

Epilepsy 5.2 Reporting and Verification

The practice reports the number of patients aged 18 and over on its epilepsy disease register and the number of patients aged 18 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 recognising that reported prevalence will be reduced as the register is limited to those receiving drug treatment.

Epilepsy Indicator 6

The percentage of patients aged 18 and over on drug treatment for epilepsy who have a record of seizure frequency in the previous 15 months

Epilepsy 6.1 Rationale

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

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

Grade C Recommendation SIGN 70 (2003)

Further information: <http://www.sign.ac.uk/guidelines/fulltext/70/index.html>

NICE clinical guideline 20 (2004) suggests that 'all individuals with epilepsy should have a regular structured review ...in adults this review should be carried out at least yearly by either a generalist or a specialist.' This guidance therefore supports the current epilepsy indicators which are in essence the component parts of an annual structured face to face review, where clinically appropriate.

Further information:

<http://www.nice.org.uk/guidance/index.jsp?action=byID&o=10954>

Clinical Standards Advisory Group. Services for Patients with Epilepsy. 2000. London. Department of Health.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009240

Epilepsy 6.2 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 7

The percentage of patients aged 18 and over on drug treatment for epilepsy who have a record of medication review involving the patient and/or carer in the previous 15 months

Epilepsy 7.1 Rationale

See Epilepsy 6.1

The involvement of the patient and/or carer is included to stress the importance of a face to face medication review, where clinically appropriate.

Epilepsy 7.2 Reporting and Verification

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

Epilepsy Indicator 8

The percentage of patients aged 18 and over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the previous 15 months

Epilepsy 8.1 Rationale

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

However, it is recognised that seizure control is often under the influence of factors outside the general practitioner's control. It is expected that exception-reporting in the epilepsy data set will be more common than in other chronic conditions (e.g. for patients with forms of brain injury which mean that their seizures cannot be controlled, patients who find the side effects of medication intolerable etc).

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

Leaflets for patients with epilepsy, including advice about medication, are available through Epilepsy Scotland on the link below:

http://www.epilepsyscotland.org.uk/information_section/healthpro/information_healthpro.html

Epilepsy 8.2 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.

Hypothyroid

Indicator	Points	Payment stages
Records		
THYROID 1. The practice can produce a register of patients with hypothyroidism	1	
Ongoing Management		
THYROID 2. The percentage of patients with hypothyroidism with thyroid function tests recorded in the previous 15 months	6	40-90%

Hypothyroidism - Rationale for Inclusion of Indicator Set

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

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

Monitoring of hypothyroidism is almost entirely undertaken in primary care.

THYROID Indicator 1

The practice can produce a register of patients with hypothyroidism

Thyroid 1.1 Rationale

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

Thyroid 1.2 Reporting and Verification

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

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

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).

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 PCO:

- i. Inspection of the output from a computer search that has been used to provide information on this indicator.
- ii. Inspection of a sample of records of patients with hypothyroidism to look at the proportion with recorded TSH/T4.
- iii. 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
Records		
CANCER 1. The practice can produce a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers from 1 April 2003'	5	
Ongoing Management		
CANCER 3. The percentage of patients with cancer, diagnosed within the last 18 months who have a patient review recorded as occurring within 6 months of the practice receiving confirmation of the diagnosis	6	40-90%

Cancer - Rationale for Inclusion of Indicator Set

Cancer is a clinical priority in all four countries. It is recognised that the principal active management of cancers occurs in the secondary care setting. General 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 but does represent Good Professional Practice.

Cancer Indicator 1

The practice can produce a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers from 1 April 2003'

Cancer 1.1 Rationale

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

Cancer 1.2 Reporting and Verification

The practice reports the number of patients added to its cancer register in the 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 3

The percentage of patients with cancer, diagnosed within the last 18 months who have a patient review recorded as occurring at 6 months after the practice has received confirmation of the diagnosis

Cancer 3.1 Rationale

Most general practitioners will see patients with a new cancer diagnosis following assessment and management in a secondary or tertiary care setting. A cancer review is an opportunity to cover the following issues:

- The patient's individual health and support needs (this will vary with e.g. the diagnosis, staging, age and pre-morbid health of the patient and their social support networks)
- The co-ordination of care between sectors.

Further information: Better Cancer Care: An Action Plan

<http://www.scotland.gov.uk/Publications/2008/10/24140351/0>

<http://www.scotland.gov.uk/Topics/Health/health/cancer>

Cancer 3.2 Reporting and Verification

The practice reports the number of patients with cancer diagnosed in the last 18 months with a review recorded in the six months after diagnosis.

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.

Palliative Care

Indicator	Points	Payment Stages
Records		
PC3: The practice has a complete register available of all patients in need of palliative care/support irrespective of age	3	
Ongoing Management		
PC2: The practice has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed.	3	

Palliative Care- Rationale for Inclusion of Indicator Set

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

In Scotland, “Living and Dying Well, a national action plan for palliative and end of life care in Scotland” 2008 places great emphasis on the role of primary care in providing palliative care for all patients with such needs, regardless of diagnosis. The action plan uses the concepts of planning and delivery of care, and of communication and information sharing as a framework to support a person centred approach to delivering consistent palliative and end of life care in Scotland.

<http://www.scotland.gov.uk/Publications/2008/10/01091608/0>

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

- over 99% of practices now using a palliative care register since the introduction of this indicator set
- specific emphasis on the inclusion of patients with non-malignant disease and of all ages since April 2008
- patients and carers being offered more choice regarding their priorities and preferences for care including their preferred place of care in the last days of life. (Evidence shows that more patients achieve a home death if they have expressed a wish to do so.)
- increasing use of anticipatory prescribing to enable rapid control of symptoms if needed and a protocol or integrated care pathway for the final days of life.
- identification of areas needing improvement by the National Audit Office e.g. un-necessary hospital admissions during the last months of life¹⁹

¹⁹ ‘In one PCT 40 per cent of patients who died in hospital in October 2007 did not have medical needs which required them to be treated in hospital, and nearly a quarter of these had been in hospital for over a month’ National Audit Office End of Life Care report November 2008)

The National EOLC Strategy and “Living and Dying Well” suggest that all practices should adopt a systematic approach to end of life care and work to develop measures and markers of good care. They recommend the Gold Standards Framework (GSF) and the associated After Death Analysis (ADA) as examples of good practice. Evidence suggests that over 60% of practices across the UK now use GSF to some degree to improve provision of palliative care by their primary care team.

The introduction of Gold Standard Framework (GSF) to primary care and its associated audit tool, the ADA are associated with a considerable degree of research and evaluation. GSF provides ideas and tools that help practices to focus on implementing high quality patient centred care.

www.goldstandardsframework.nhs.uk

Palliative care (PC) indicator 3

The practice has a complete register of all patients in need of palliative care/support, irrespective of age.

Palliative care 3.1 Rationale

About 1% of the population in the UK die each year (over half a million), an average of 20 deaths per GP per year. A quarter of all deaths are due to cancer, a third from organ failure, a third from frailty or dementia, and only one twelfth of patients have a sudden death. It should be possible therefore to predict the majority of deaths, however, this is difficult, with errors occurring, 30 per cent of the time. Two thirds of errors are based on over optimism and one third on over pessimism. However the considerable benefits of identifying these patients include providing the best health and social care to both patients and families and avoiding crises, by prioritising them and anticipating need.

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

20

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

1. their death in the next 12 months can be reasonably predicted (rather than trying to predict, clinicians often find it easier to ask themselves ‘the surprise question’ – ‘Would I be surprised if this patient were still alive in 12 months?’)
2. they have advanced or irreversible disease and clinical indicators of progressive deterioration and thereby a need for palliative care e.g. they have 1 core and 1 disease specific indicator in accordance with the GSF Prognostic Indicators Guidance (see QOF section of GSF website www.goldstandardsframework.nhs.uk)
3. they are entitled to a DS 1500 form. (The DS 1500 form is designed to speed up the payment of financial benefits and can be issued when a patient is considered to be approaching the terminal stage of their illness. For these purposes, a patient is considered as terminally ill if they are suffering from a progressive disease and are not expected to live longer than six months.)

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

Palliative care 3.2 Reporting and verification

The practice reports the number of patients on its palliative care register.

Verification – in the rare case of a nil register at year end, if a practice can demonstrate that it had a register in year then it will be eligible for payment.

Palliative care indicator 2

The practice has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed.

Palliative care 2.1 Rationale

The QOF monitors occurrence of the multi-disciplinary meetings but it is up to the practice to ensure the meetings are effective. The aims of the meetings are to:

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

Many practices find use of a checklist during the meeting to ensure all aspects of care are covered is useful e.g. SCR1 and 2 templates and assessment tools on the GSF website.

Scottish practices participating in the Palliative Care DES will have access to a reporting template which can be used and adapted for this purpose and available at annex D:

[http://www.sehd.scot.nhs.uk/pca/PCA2008\(M\)12.pdf](http://www.sehd.scot.nhs.uk/pca/PCA2008(M)12.pdf)

Palliative care 2.2 Reporting and verification

The practice should submit written evidence to the PCO describing the system for initiating and recording meetings.

Mental Health

Indicator	Points	Payment stages
Records		
MH 8. The practice can produce a register of people with schizophrenia, bipolar disorder and other psychoses	4	
Ongoing management		
MH 9. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses with a review recorded in the preceding 15 months. In the review there should be evidence that the patient has been offered routine health promotion and prevention advice appropriate to their age, gender and health status	23	40-90%
MH 4. The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 15 months	1	40-90%
MH 5. The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the previous 6 months	2	40-90%
MH6: The percentage of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate	6	25-50%
MH7: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who do not attend the practice for their annual review who are identified and followed up by the practice team within 14 days of non-attendance	3	40-90%

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. This reflects the complexity of mental health problems, and the complex mix of physical, psychological and social issues that present to general practitioners. The indicators included in the QOF can therefore only be regarded as providing a 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 significant event audits which focus specifically on mental health problems and methods of addressing the needs of carers. This indicator set now

focuses on patients with serious mental illness and there are indicator sets that focus on people with depression and dementia

Mental Health (MH) Indicator 8

The practice can produce a register of people with schizophrenia, bipolar affective disorder and other psychoses

MH 8.1 Rationale

The register now includes all people with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses rather than a generic phrase that is open to variations in interpretation. This brings mental health in line with other areas of the QOF.

The notion of agreeing to regular follow up has also been removed to acknowledge the variation in interpretation of this clause and to bring the indicator in line with the rest of the QOF.

MH 8.2 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 9

The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses with a review recorded in the preceding 15 months. In the review there should be evidence that the patient has been offered routine health promotion and prevention advice appropriate to their age, gender and health status

MH 9.1 Rationale

Patients with serious mental health problems are at considerably increased risk of physical ill-health than the general population (Marder et al. Am J Psychiatry 2004; 161: 1334-49).

It is therefore good practice for a member of the practice team to review each patient's physical health on an annual basis.

Health promotion and health prevention advice is particularly important for people with serious mental illness however there is good evidence that they are much less likely than other members of the general population to be offered, for example, blood pressure checks and cholesterol checks if they have concurrent coronary heart disease, and cervical screening.

People with serious mental illness are also far more likely to smoke than the general population (61% of people with schizophrenia and 46 % of people with bipolar disorder smoke compared to 33% of the general population). Premature death and smoking-related diseases, such as respiratory disorders and heart disease, are,

however, more common among people with serious mental illness who smoke, than in the general population of smokers (Seymour L. Not all in the mind: the physical health of mental health service users. Mentality, 2003).

People with schizophrenia appear to be at increased risk of impaired glucose tolerance and diabetes, and this is independent of treatment with the newer atypical antipsychotic drugs

The Nice clinical guidelines on schizophrenia (2002) recommended physical health checks for diabetes, blood pressure, lipids, and smoking (Good Practice point). The NICE clinical guideline on bipolar disorder (2006) has recommended that people with bipolar disorder should have an annual physical health review, normally in primary care, to ensure that the following are assessed each year: lipid levels, including cholesterol in all patients over 40 even if there is no other indication of risk, plasma glucose levels, weight, smoking status, alcohol use, and blood pressure. See also the Disability Rights Commission Equal Treatment: Closing the Gap – One year on.

www.learningdisabilitiesuk.org.uk/docs/DRCrpt.pdf

Mental Health in Scotland :Improving the Physical Health and Well Being of those Experiencing Mental Illness

Link to guidance document

<http://www.scotland.gov.uk/Publications/2008/11/28152218/0>

A review of physical health will therefore normally) include:

1. an enquiry about smoking, alcohol or drug use
2. a blood pressure check)
3. a cholesterol checks where clinically indicated
4. measurement of body mass index (BMI)
5. a check for the development of diabetes
6. cervical screening where appropriate
- 7 an enquiry about cough,sputum and wheeze

The accuracy of medication prescribed by the General Practitioner can also be checked at the same time.

MH 9.3 Reporting and Verification

The practice should report the percentage of patients on the mental health register who have been reviewed in the previous 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 components have been undertaken and recorded.

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

The number of points and indicators for Lithium have been reduced in recognition of the relatively small number of people this indicator applies to and the importance of the intermediate outcome of the lithium level being within the therapeutic range.

It is important to check thyroid and renal function on an annual basis since 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 per cent and 15 per cent of people on lithium.

See <http://www.medicine.ox.ac.uk/bandolier/band74/b74-6.html>.

MH 4.2 Reporting and Verification

MH 4.2.1 Practices should report the percentage of patients on lithium therapy with a record of TSH in the last 15 months.

MH 4.2.2 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 PCO:

- i. Inspection of the output from a computer search that has been used to provide information on this indicator.
- ii. 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.
- iii. 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

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 e.g. thiazide diuretics or NSAIDs which may reduce lithium excretion. However, there is no definitive evidence on the frequency of lithium level checks. Most practitioners would monitor lithium levels when stable every three to six 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 patients who default where responsibility has been accepted for administering treatment.

The therapeutic range for patients on lithium therapy is normally 0.4 -1.0 mmol/l (see the British National Formulary). If the range differs locally, the PCO will be required to allow for this.

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 previous six months.

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

- i. Inspection of the output from a computer search that has been used to provide information on this indicator.
- ii. Inspection of a sample of records of patients on lithium therapy to look at the proportion with recorded serum lithium in the therapeutic range.
- iii. Inspection of a sample of records of patients on lithium therapy for whom a record of serum lithium in the therapeutic range is claimed, to see if there is evidence of this in the medical records.

Mental Health (MH) Indicator 6

The percentage of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate

MH 6.1: Rationale

This new indicator reflects good professional practice and supported by national Clinical Guidelines

<http://www.nice.org.uk/guidance/index.jsp?action=byID&o=10916>

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

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

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

- i. Patient's current health status and social care needs including how needs are to be met, by whom, and the patient's expectations.
- ii. How socially supported the individual is: e.g. friendships/family contacts/voluntary sector organisation involvement.
People with mental health problems have fewer social networks than average, with many of their contacts related to health services rather than sports,

family, faith, employment, education or arts and culture. One survey found that 40 per cent of people with ongoing mental health problems had no social contacts outside mental health services (See Ford et al. *Psychiatric Bulletin* 1993; 17(7): 409-411 and Office of the Deputy Prime Minister Mental health and social exclusion (Social Exclusion Unit Report). London, ODPM, 2004).

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

In England, only 24 per cent of people with mental health problems are currently in work, the lowest employment rate of any group of people (ONS Labour Force Survey, Autumn 2003). People with mental health problems also earn only two-thirds of the national average hourly rate (ONS, 2002). Studies show a clear interest in work and employment activities amongst users of mental health services with up to 90 per cent wishing to go into or back to work (See Grove and Drurie. (Social firms: an instrument for social and economic inclusion. Redhill, Social Firms UK, 1999)

- v. Early Warning Signs.

“Early warning signs” from the patient’s perspective that may indicate a possible relapse (See Birchwood et al. *Advances in Psychiatric Treatment* 2000; 6: 93-101 and Birchwood and Spencer. *Clinical Psychology Review* 2001; 21(8): 1211-26). Many patients may already be aware of their early warning signs (or relapse signature) but it is important for the primary care team to also be aware of noticeable changes in thoughts, perceptions, feelings and behaviours leading up to their most recent episode of illness as well as any events the person thinks may have acted as triggers.

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

A care plan should be accurate, easily understood, reviewed as part of the annual review and discussed with the patient, their family and/or carers.

If a patient is treated under the care programme approach (CPA), then they should have a documented care plan discussed with their community key worker available. This is acceptable for the purposes of the QOF.

Further Information:

Mental Health (Care and Treatment) (Scotland) Act 2003

<http://www.scotland.gov.uk/Topics/Health/health/mental-health/mhlaw/the2003act>

MH 6.2 Reporting and Verification

The practice reports the percentage of patients on the mental health register who have a comprehensive care plan recorded.

Mental Health (MH) Indicator 7

The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who do not attend the practice for the annual review who are identified and followed up by the practice team within 14 days of non attendance

MH 7.1: Rationale

Poor compliance with medication is well recognised, and it is estimated that around 50 per cent of people with schizophrenia do not always take their medication regularly. This may lead to relapse, hospitalisation and poorer outcome (Csernansky and Schuchart. CNS Drugs 2002; 16 (7): 473-484). There is also evidence to suggest that non-attendance at appointments may be interpreted by some practices as “irrationality,” as part of having a serious mental illness, rather than recognising that not turning up for an appointment may be a sign of relapse (Lester et al. BMJ. 2005; 330: 1122-28).

This indicator requires proactive intervention from the practice to contact the patient and enquire about their health status. This may be through telephone contact, letter (only if there is no phone number recorded) or visit where appropriate. If the person is in contact with secondary care, it will be appropriate to contact their key worker to discuss any concerns. Evidence will be required as to how this contact has been made.

MH 7.2: Reporting and Verification

Practices report the percentage of patients who did not attend their annual review who have been followed up within 14 days of their non-attendance.

Asthma

Indicator	Points	Payment stages
Records		
ASTHMA 1. The practice can produce a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the previous twelve months	4	
Initial Management		
ASTHMA 8. The percentage of patients aged eight and over diagnosed as having asthma from 1 April 2006 with measures of variability or reversibility	15	40-80%
Ongoing management		
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	40-80%
ASTHMA 6. The percentage of patients with asthma who have had an asthma review in the previous 15 months	20	40-70%

Asthma - Rationale for Inclusion of Indicator Set

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

This indicator set was 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 previous 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. Some of the symptoms of asthma are shared with diseases of other systems. Features of an airway disorder in adults such as cough, wheeze and breathlessness

should be corroborated where possible by measurement of airflow limitation and reversibility. Obstructive airways disease produces a decrease in peak expiratory flow (PEF) and forced expiratory volume in one second (FeV1) which persist after bronchodilators have been administered. One or both of these should be measured, but may be normal if the measurement is made between episodes of bronchospasm. If repeatedly normal in the presence of symptoms, then a diagnosis of asthma must be in doubt.

A proportion of patients with COPD will also have asthma i.e. they have large reversibility – 400mls or more on FeV1 – but do not return to over 80 per cent predicted, and have a significant smoking history. From 1 April 2006 these patients should be recorded on both the asthma and COPD registers.

Children

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

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

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 Guideline 101 (SIGN and BTS) British Guideline on the Management of Asthma 2008

www.sign.ac.uk/pdf/qrg101.pdf

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

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

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

Asthma 1.2 Reporting and Verification

Asthma 1.2.1 Practices should report the number of patients with active asthma (i.e. a diagnosis of asthma, excluding those who have had no prescription issued for an

asthma-related drug in the previous 12 months), and the number of patients with active asthma (i.e. diagnosis of asthma, excluding those who have had no prescription issued for an asthma-related drug in the previous 12 months) as a proportion of their practice list size.

Asthma 1.2.2 Practices should be able to report the number of patients with inactive asthma (i.e. those who have a diagnosis of asthma who have had no asthma-related drug issued in the previous 12 months) and the number of patients with inactive asthma (i.e. those who have a diagnosis of asthma who have had no asthma-related drug issued in the previous 12 months) as a proportion of their practice list size.

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

Asthma Indicator 8

The percentage of patients aged eight and over, diagnosed as having asthma from 1 April 2006 with measures of variability or reversibility

Asthma 8.1 Rationale

Accurate diagnosis is fundamental in order to avoid untreated symptoms as a result of under-diagnosis, and inappropriate treatment as a result of over-diagnosis. Both scenarios have implications both to the health of the patient, and the cost of providing healthcare.

National and international guidelines emphasise the importance of demonstrating variable lung function in order to confirm the diagnosis of asthma. “Variability of PEF and FeV1, either spontaneously over time or in response to therapy is a characteristic feature of asthma.”

See SIGN Guideline 101 (SIGN and BTS) British Guideline on the Management of Asthma 2008

<http://www.sign.ac.uk/pdf/qrg101.pdf>

“...measurements of airflow limitation, its reversibility and its variability are considered critical in establishing a clear diagnosis of asthma” [Global Strategy for Asthma Management and Prevention. www.ginasthma.org]. One peak flow measurement (as required by the Asthma 2 indicator in the 2004/5 QOF) provides no information about variability and therefore can neither confirm, nor refute, the diagnosis.

Objective measurement of variability either spontaneously over time or in response to therapy is thus fundamental to the diagnosis of asthma, and may be conveniently achieved in primary care with serial peak flow measurements. Significant variability in peak flow is defined as a change of 20 per cent or greater with a minimum change of at least 60 l/min ideally for three days in a week for two weeks seen over a period of time and may be demonstrated by monitoring diurnal variation, demonstrating an increase after therapy (15 minutes after short-acting bronchodilator, after six weeks inhaled steroids, two weeks oral steroids) or a reduction after exercise or when the

patient next meets his/her trigger. Spirometry (>15 per cent and 200ml change in FeV1) may still be used to confirm variability, though the limitation imposed by a surgery-based measurement means that changes over time may be missed.

It is important to recognise that while repeated normal readings in a symptomatic patient cast doubt on a diagnosis of asthma, the natural variation of the disease means that many patients with asthma will not necessarily have significant variability at any given time. Confirmation of the diagnosis may therefore require further recordings e.g. during a subsequent exacerbation. In circumstances of persisting doubt then more specialist assessment is required which may include hyper-responsiveness testing and consideration of alternative diagnoses.

It is of note that a proportion of patients with COPD will also have asthma i.e. they have large reversibility – 400mls or more on FeV1 – but do not return to over 80 per cent predicted, and a significant smoking history. Evidence would suggest that this should not usually be more than 15 per cent of the overall COPD population.

Asthma 8.2 Reporting and Verification

The practice should report the percentage of patients aged eight or over diagnosed as having asthma after 1 April 2006 with measures of variability or reversibility.

Asthma Indicator 3

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

Asthma 3.1 Rationale

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

The number of studies of smoking related to asthma are surprisingly few in number. Starting smoking as a teenager increases the risk of persisting asthma. There are very few studies that have considered the question of whether smoking affects asthma severity. One controlled cohort study suggested that exposure to passive smoke at home delayed recovery from an acute attack. There is also epidemiological evidence that smoking is associated with poor asthma control. See Price et al. Clin Exp Allergy 2005; 35: 282-287.

It is recommended that smoking cessation be encouraged as it is good for general health and may decrease asthma severity (Thomson et al. Eur Respir J 2004; 24: 822 – 833).

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 previous 15 months.

Asthma Indicator 6

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

Asthma 6.1 Rationale

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

National and international guidelines recommend the use of standard questions for the monitoring of asthma. "Proactive structured review, as opposed to opportunistic or unscheduled review, is associated with reduced exacerbation rate and days lost from normal activity".

See SIGN Guideline 101 (SIGN and BTS) British Guideline on the Management of Asthma 2008

<http://www.sign.ac.uk/guidelines/fulltext/101/index.html>

The QOF suggests the utilisation of the RCP three questions as an effective way of assessing symptoms:

"In the last month:

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

Guidelines suggest it should be abnormal in patients with mild to moderate asthma to have any nocturnal waking or activity limitation. Asthma symptoms may be expected on up to three days per week.

If asthma appears to be uncontrolled the following should be examined as part of the asthma review before increasing asthma therapy and treated appropriately:

- smoking behaviour as smoking interferes with asthma control
- poor inhaler technique
- inadequate adherence with regular preventative asthma therapy
- rhinitis.

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

Peak flow is a valuable guide to the status of a patient's asthma especially during exacerbations. However, it is much more useful if there is a record of patients' best

peak flow, i.e. their peak flow when they are well. Many guidelines for exacerbations are based on the ratio of current to best peak flows. For patients over the age of 18 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 regularly. National and international guidelines emphasise the importance of assessing ability to use inhalers before prescribing, and regularly reviewing technique, especially if control is inadequate. “Prescribe inhalers only after patients have received training in the use of the device and have demonstrated satisfactory technique.” “Reassess inhaler technique as part of structured clinical review.”

See SIGN Guideline 101 (SIGN and BTS) British Guideline on the Management of Asthma 2008

<http://www.sign.ac.uk/guidelines/fulltext/101/index.html>

Summary of Asthma Review:

- assess symptoms (using RCP 3 questions)
- measure peak flow
- assess inhaler technique
- consider personalised asthma plan.

If asthma appears to be uncontrolled follow steps as outlined above.

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

Asthma 6.2 Reporting and Verification

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

Verification- PCOs may randomly select a number of case records of patients in which the review has been recorded as taking place in order to confirm that the four elements have been addressed.

Dementia

Indicator	Points	Payment Stages
Records		
DEM1: The practice can produce a register of patients diagnosed with dementia	5	
Ongoing management		
DEM2: The percentage of patients diagnosed with dementia whose care has been reviewed in the previous 15 months	15	25-60%

Dementia- Rationale for Inclusion of Indicator Set

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

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

Dementia (DEM) Indicator 1

The practice can produce a register of patients diagnosed with dementia

Dementia 1.1 Rationale

A register is a pre-requisite for the organisation of good primary care for a particular patient group. There is little evidence to support screening for dementia and it is expected that the diagnosis will largely be recorded from correspondence when patients are referred to secondary care with suspected dementia or as an additional diagnosis when a patient is seen in secondary care. However it is also important to include patients where it is inappropriate or not possible to refer to a secondary care provider for a diagnosis and where the GP has made a diagnosis based on their clinical judgement and knowledge of the patient.

Dementia 1.2 Reporting and Verification

The practice reports the number of patients with dementia on its register and the number of people with dementia as a proportion of its list size.

Dementia (DEM) Indicator 2

The percentage of patients diagnosed with dementia whose care has been reviewed in the previous 15 months

Dementia 2.1 Rationale

The face to face review should focus on support needs of the patient and their carer. In particular the review should address four key issues:

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

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

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

Depression should also be considered since it is more common in people with dementia than those without (Burt et al. Psychol Bull 1995; 117: 285-305).

The Audit Commission Report Forget Me Not 2002. www.audit-commission.gov.uk/Products/NATIONAL-REPORT/3DFEF403-038C-464f-8518-441477E92B15/forgetupdate.pdf

and the NSF for Older People

www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4003066&chk=wg3bg0

http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_4003066

Both recommend that patients and carers should be given relevant information about the diagnosis and sources of help and support (bearing in mind issues of confidentiality). Evidence suggests that healthcare professionals can improve satisfaction for carers by acknowledging and dealing with their distress and providing more information on dementia (Eccles et al. BMJ 1998; 317: 802-808). As the illness progresses, needs may change and the review may focus more on issues such as respite care.

There is good evidence from well-designed cohort studies and case control studies of the benefit of healthcare professionals asking about the impact of caring for a person with dementia and the effect this has on the caregiver. It is important to remember that male carers are less likely to complain spontaneously and that the impact of caring is

dependent not on the severity of the cognitive impairment but on the presentation of the dementia, for example, on factors such as behaviour and affect. If the carer is not registered at the practice, but the GP is concerned about issues raised in the consultation, then with appropriate permissions, they should contact the carer's own GP for further support and treatment (see Eccles et al. BMJ 1998; 317: 802-808).

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

SIGN Guideline 86 Managing patients with dementia

<http://www.sign.ac.uk/pdf/sign86.pdf>

Coping with Dementia – a Handbook for Carers” has been updated and widely distributed.

<http://www.healthscotland.com/uploads/documents/7632-CopingWithDementia2008.pdf>

Dementia 2.2 Reporting and Verification

The practice reports the percentage of patients with dementia on its register who have had their care reviewed in the previous 15 months.

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

Depression

Indicator	Points	Payment Stages
Diagnosis and initial management		
DEP1: The percentage of patients on the diabetes register and /or the CHD register for whom case finding for depression has been undertaken on one occasion during the previous 15 months using two standard screening questions	8	40-90%
DEP2: In those patients with a new diagnosis of depression, recorded between the preceding 1 April to 31 March, the percentage of patients who have had an assessment of severity at the outset of treatment using an assessment tool validated for use in primary care	25	40-90%
DEP3: In those patients with a new diagnosis of depression and assessment of severity recorded between the preceding 1 April to 31 March, the percentage of patients who have had a further assessment of severity 5-12 weeks(inclusive) after the initial recording of the assessment of severity. Both assessments should be completed using an assessment tool validated for use in primary care.	20	40-90%

Depression – Rationale for Inclusion of the Indicator Set

Depression is common and disabling. The estimated point prevalence for major depression among 16-65 year olds in the UK is 21/1000 (males 17, females 25). Mixed anxiety and depression is prevalent in a further 10 per cent of adult patients attending general practices (NICE Depression Guideline, December 2004). It contributes 12 per cent of the total burden of non-fatal global disease and by 2020, looks set to be second after cardiovascular disease in terms of the world's disabling diseases (Murray CJL and Lopez AD. The global burden of disease. Boston, Mass: WHO and Harvard University Press, 1996). Major depressive disorder is increasingly seen as chronic and relapsing, resulting in high levels of personal disability, lost quality of life for patients, their family and carers, multiple morbidity, suicide, higher levels of service use and many associated economic costs. In 2000, 109.7 million lost working days and 2615 deaths were attributable to depression. The total annual cost of adult depression in England has been estimated at over £9 billion, of which £370 million represents direct treatment costs.

Further information:

Depression. Management of depression in Primary and Secondary Care. Clinical Guideline 23. NICE, London 2004.

<http://www.nice.org.uk/guidance/index.jsp?action=byID&o=10958>

Depression (DEP) indicator 1

The percentage of patients on the diabetes register and/or the CHD register for whom case finding for depression has been undertaken on one occasion during the previous 15 months using two standard screening questions

Depression 1.1 Rationale

Depression is more common in people with coronary heart disease and presence of depression is associated with poorer outcomes. Up to 33 per cent of patients develop depression after a myocardial infarction (Davies et al. BMJ 2004; 328: 939-943).

The presence of depression in people with coronary heart disease is associated with reduced compliance with treatment, increased use of health resources, increased social isolation, and poorer outcomes (Carney et al, American Journal of Cardiology 2003;92(11): 1277-81).

A meta-analysis of 20 trials (Barth et al. Psychosomatic Medicine 2004; 66: 802-13) found that depressive symptoms and clinical depression in people with CHD increased mortality for all follow up periods even after adjustment for other risk factors. In other words, depression was an independent risk factor for mortality in people with CHD. There is Grade A evidence from two randomised controlled trials that SSRI antidepressant treatment in people with coronary heart disease is safe and effective in reducing depression, at least among those with a prior history of depression and more severe symptoms (Glassman et al. Journal of the American Medical Association 2002; 288: 701-709; . Taylor et al. Archives of General Psychiatry 2005; 62: 792-798). Patients treated with an SSRI were also found to have a 42% reduction in death or recurrent MI in a sub-group analysis of outcomes in a trial of cognitive behavioural therapy (CBT), although this was a post-hoc observation, and assignment to antidepressants was not randomised (Lesperance et al. Journal of the American Medical Association 2007; 297: 367-379).

There is a 24 per cent lifetime prevalence of co-morbid depression in individuals with diabetes mellitus (Goldney et al. Diabetes Care 2004; 27(5): 1066-70), a prevalence rate three times higher than the general population. A recent meta-analysis of 42 studies found that depression is clinically relevant in nearly one in three patients with diabetes (Anderson et al. Diabetes Care 2001; 24: 1069-78). People with both diabetes and depression are less physically and socially active (Von Korf et al. Psychosomatic Medicine 2005; 67: 233-40) and less likely to comply with diet and treatment than people with diabetes alone, leading to worse long term complications and higher mortality. It may also be that practitioners provide poorer care to patients with co-morbid depression and diabetes because depression impairs communication with patients (Piette et al. American Journal of Managed Care 2004; 10: 152-162). There is good evidence from five randomised controlled trials that effective treatment with either antidepressants or CBT improves the outcome of depression in patients with diabetes (Lustman et al. Psychosomatic Medicine 1997; 59: 241-50; Lustman et al. Annals of Internal Medicine 1998; 129: 613-621; Lustman et al. Diabetes Care 2000; 23: 618-23; Katon et al. Archives of General Psychiatry 2004; 61: 1042-49; Williams et al. Annals of Internal Medicine 2004; 140: 1015-24). While treatment has not been shown consistently to improve glycaemic control, psychological well-being has been identified as an important goal of diabetes management in its own right by the St Vincent Declaration.

NICE guidance on Depression suggests that “screening should be undertaken in primary care ...for depression in high-risk groups” (Grade C) and that “screening for depression should include the use of at least two questions concerning mood and interest:

- During the last month, have you often been bothered by feeling down, depressed or hopeless?; and
- During the last month, have you often been bothered by having little interest or pleasure in doing things?"

(NICE Grade B).

A "yes" answer to either question is considered a positive test. A "no" response to both questions makes depression highly unlikely. These two brief questions could be asked as part of a diabetes or coronary heart disease review and patients who answer "yes" to either questions could be referred to the GP for further assessment of other symptoms such as tiredness, guilt, poor concentration, change in sleep pattern and appetite and suicidal ideation to confirm a diagnosis of depression. This assessment should be informed by using a questionnaire measure of severity such as the PHQ-9, HADS, or BDI, as used for the DEP 2 indicator.

(see also Whooley et al. *Journal of General Internal Medicine* 1997; 12 (7): 439-45).

The specificity of screening has been shown to be improved by the addition of a third 'help' question asked of patients answering 'yes' to either of the first two questions: Is this something with which you would like help? (Arnoll et al. *British Medical Journal* 2005; doi:10.1136/bmj.38607.464537.7c) This third question has three possible responses: 'no', 'yes, but not today', or 'yes'. A 'no' response to this third question makes major depression highly unlikely (negative predictive value NPV of 94%). It is important to stress therefore that a negative result to the two to three item screen can usually be taken to indicate that the patient doesn't have depression.

Depression 1.2 Reporting and Verification

Practices report the percentage of patients on their diabetes and CHD registers whose records show that they have been screened for depression using the two standard questions. This screening will have been recorded in the previous 15 months. These questions should be asked as part of a consultation and should not be posted to patients.

Verification – PCOs may randomly select a number of case records of patients in whom screening has been undertaken to ensure that the two standard questions are being used.

Depression (DEP) Indicator 2

In those patients with a new diagnosis of depression recorded between the preceding 1 April to 31 March, the percentage of patients who have had an assessment of severity at the outset of treatment using an assessment tool validated for use in primary care

Depression 2.1 Rationale

This indicator applies to adults aged 18 years and over with a new diagnosis of depression in the preceding 1 April to 31 March. It does not include women with postnatal depression.

Assessment of severity is essential to decide on appropriate interventions and improve the quality of care.

A measure of severity at the outset of treatment enables a discussion with the patient about relevant treatment interventions and options, guided by the stepped care model of depression described in NICE guidance. The guidance states, for example, that antidepressants are not recommended for the initial treatment of mild depression but should be routinely considered for all patients with moderate or severe depression. The British Association of Psychopharmacology Guidelines state that antidepressants are a first-line treatment for moderate to severe major depression irrespective of environmental factors and that antidepressants are not indicated for milder depressions unless it has persisted for two years or more ('dysthymia') (Anderson et al. Journal of Psycho-pharmacology 2000; 14: 3-20).

The three suggested severity measures validated for use in a primary care setting are the Patient Health Questionnaire (PHQ-9), the Beck Depression Inventory Second Edition (BDI-II) and the Hospital Anxiety and Depression Scale (HADS). It is advisable for a practice to choose one of these three measures and become familiar with its questions and scoring systems.

Patient Health Questionnaire (PHQ-9)

The PHQ-9 is a nine question self-report measure of severity that takes approximately three minutes to complete. It uses DSM-IV criteria and scores are categorised as minimal (1-4), mild (5-9), moderate (10-14), moderately severe (15-19) and severe depression (20-27).

It was developed and validated in the US and can be downloaded free of charge from: www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/questionnaire/

Hospital Anxiety and Depression Scale (HADS)

Despite its name, the HADS has been validated for use in community and primary care settings. It is self administered and takes up to five minutes to complete. The Anxiety and Depression scales both comprise seven questions rated from a score of 0 to 3 depending on the severity of the problem described in each question. The two sub-scales can also be aggregated to provide an overall anxiety and depression score. The anxiety and depression scores are categorised as normal (0-7), mild (8-10), moderate (11-14) and severe (15-21).

The HADS allows you to establish the severity of both anxiety and depression simultaneously, whilst giving a separate score for each since the two subscales, anxiety and depression are independent measures. The HADS can be ordered from:

<http://shop.gl-assessment.co.uk/home.php?cat=417&gclid=CPPr3fJhpkCFQ6wQwodl2Krlw>

The HADS depression subscale (HAD-D) has 90 per cent sensitivity and 86 per cent specificity for depression compared to the gold standard of a structured diagnostic interview.

Further information:

Zigmond AS, Snaith RP. *Acta Psych Scand* 1983; 67: 361-70 and Wilkinson and Barczak. *J R Coll Gen Pract* 1988; 38: 311-3.

Beck Depression Inventory Second Edition (BDI-II)

The BDI-II is a 21 item self report instrument that uses DSM-IV criteria. It takes approximately five minutes to fill in. A total score of 0-13 is considered minimal range, 14-19 is mild, 20-28 is moderate, and 29-63 is severe. The instruments and manuals can be ordered on line from:

<http://www.pearson-uk.com/product.aspx?n=1316&s=1322&cat=1426&skey=2646&gclid=Cluxq5CioZMCFQ6KMAodj16TrQ>

For further information:

Arnau et al. *Health Psychology* 2001; 20(2): 112-9.

Not all severity assessment measures map directly onto NICE guidance, which uses ICD-10 symptoms in defining mild, moderate, severe and severe depression with psychotic symptoms. However, the underlying principle of all three suggested measures is that a higher score indicates greater severity requiring different types of treatment.

Recent research has shown that the use of severity measures is valued by patients and that doctors' treatment and referral rates are related to the scores on the measures. Qualitative interviews with patients who had been assessed with the measures revealed that they saw them as evidence that GPs were carrying out a full assessment which helped them to receive treatment in line with the severity of their depression. The measures also helped some patients to understand how their different symptoms made sense when considered together as the syndrome of depression²¹.

Prior to the introduction of the questionnaire measures into the QOF, an audit was carried out of the use of the Hospital Anxiety and Depression scale depression subscale (HAD-D) by volunteer GPs in Southampton²². The likelihood of being prescribed an antidepressant increased significantly with severity on the HAD-D measure and was associated with improved targeting of antidepressant treatment when compared to a study carried out in the same area prior to the introduction of the HAD-D measure²³.

A more recent analysis of the use of the two most commonly used measures (the PHQ-9 and HAD-D) in 38 practices in three centres also found that rates of treatment and referral increased logically in line with higher scores. However, it was found that

²¹ Dowrick et al, *British Medical Journal*, in press

²² Kendrick. *British Journal of General Practice* 2006; 56: 796-797

²³ Kendrick et al. *British Journal of General Practice* 2005; 55: 280-286



overall rates of treatment and referral were very similar for patients assessed with either measure, despite the fact that the PHQ-9 classified significantly more patients as moderately to severely depressed and in need of treatment, compared to the HAD-D. These results suggest practitioners do not decide on drug treatment or referral on the basis of the severity questionnaire scores alone²⁴. They also suggest that the two most commonly used measures are inconsistent, the PHQ-9 rating more people above the recommended threshold for intervention than the HAD-D. This is consistent with other new evidence suggesting the thresholds for intervention for these instruments should be revised.

Recommended thresholds for intervention (revised)

A study in which the PHQ-9 and HAD-D were administered together to a single sample of patients also found that a greater proportion of the sample was classified as depressed according to the PHQ-9 than according to the HAD-D²⁵. Validation studies against more extensive ‘gold standard’ diagnostic assessments have suggested that the validity of the measures in terms of identifying major depressive disorder could be improved by using a more conservative cut-off score of 12 rather than 10 on the PHQ-9, and a less conservative cut-off of 10 rather than 11 on the HAD-D²⁶. Changing the recommended threshold scores for intervention would therefore make these measures more valid against longer assessments, more consistent with each other, and more consistent with practitioners’ clinical judgment.

The revised recommended thresholds for considering intervention are therefore:

- PHQ-9 score: 12
- HAD-D score: 10
- BDI-II score: 20

It is, however, important to stress that symptom scores alone should not be used to determine the presence of depression which needs treatment.

It is also important for clinicians to consider family and previous history as well as the degree of associated disability and patient preference in making an assessment of the need for treatment, rather than relying completely on a single symptom count at one point in time.

So decisions about treatment and referral should take into account:

- severity of symptoms (assessed clinically as well as with a measure)
- functional impairment (significant effects on work and daily activities)
- duration (watchful waiting for around eight weeks for mild symptoms)
- course (trajectory of scores, past history)

²⁴ Kendrick et al, *British Medical Journal*, in press

²⁵ Cameron et al, *British Journal of General Practice* 2008; 58:32-36

²⁶ Lowe et al, *Journal of Affective Disorders* 2004; 78:131-140; Gilbody et al, *British Journal of General Practice* 2007; 57:650-652

In addition, the PHQ-9 and the BDI-II have not been validated in terms of their cultural sensitivity and it is important to bear this in mind if using them with black and minority ethnic populations.

Depression 2.3 Reporting and Verification

Practices report the percentage of patients with a new diagnosis of depression whose notes record that they have had an assessment of severity at the outset of treatment. New diagnoses are those which have been made between the preceding 1 April to 31 March. For the purposes of QOF measurement 'at the outset of treatment' is defined as within 28 days of the initial diagnosis.

Practice also report in each patient record which of the three assessment tools they used.

Verification- PCOs may randomly select a number of case records of patients with a new diagnosis of depression to verify that their notes record an assessment of severity.

Depression (DEP) indicator 3

In those patients with a new diagnosis of depression and assessment of severity recorded between the preceding 1 April to 31 March, the percentage of patients who have had a further assessment of severity 5-12 weeks (inclusive) after the initial recording of the assessment of severity. Both assessments should be completed using an assessment tool validated for use in primary care. (As described in the rationale for depression 2 above.)

Depression 3.1 Rationale

The rationale for such follow-up measurement is derived from the recognition that depression is often a chronic disease, yet treatment is often episodic and short-lived²⁷.

If treatment with antidepressants is initiated, then patients should be being followed up regularly for several months. Early cessation of treatment is associated with a greater risk of relapse, and the 2004 NICE guidelines on depression recommend initial treatment for six months after recovery. One study showed that only around one third or less of patients prescribed antidepressants were still receiving medication at 4-6 months²⁸. Recent analysis of the GP Research Database for the years 1993 to 2005 has confirmed this finding: more than half of the patients treated with antidepressants for a new diagnosis of depression during those years received prescriptions for only one or two months of treatment and that pattern had not changed over the 13 year period²⁹. If treatment is not started after the initial diagnosis then NICE guidance suggests patients should in any case be reassessed over one to two months, to see whether their symptoms have resolved or worsened to the point where treatment becomes advisable ('watchful waiting').

²⁷ Kates and Mach, *Canadian Journal of Psychiatry* 2007; 52(2): 77-85

²⁸ Donoghue et al, *Acta Psychiatrica Scandinavica* 2000; 101: (suppl 403) 57-61

²⁹ Kendrick et al, Society for Academic Primary Care Annual Scientific Meeting, London, July 2007

Recent research into the use of severity measures has shown that patients whose GPs used the measures for follow-up in addition to initial assessment valued having repeated scores to help monitor their progress and assess the effectiveness of treatment³⁰. When asked, most of the GPs interviewed for the same study also believed that there was value in repeating the score as a way of monitoring patients' progress.

The PHQ-9 has been shown to be a responsive and reliable measure for gauging response to treatment in individual patient care³¹.

Depression 3.2 Reporting and verification

Practices report the percentage of patients with a new diagnosis of depression whose notes record that they have had an assessment of severity 5-12 weeks (inclusive) after the initial recording of the assessment of severity related to a new diagnosis of depression. New diagnoses are those which have been made between the preceding 1 April to 31 March. To be included in the numerator for this indicator a patient needs to have had both an initial and a subsequent severity assessment.

Practices also report in each patient record which of the three assessment tools they used.

Verification – PCOs may randomly select a number of case records of patients with a new diagnosis of depression to verify that their notes record a follow-up assessment of severity 5-12 weeks after the initial assessment of severity.

³⁰ Dowrick et al, *British Medical Journal*, in press
³¹ Lowe et al,
Medical Care 2004; 42: 1194-1201



Chronic Kidney Disease (CKD)

Indicator	Points	Payment stages
Records		
CKD1: The practice can produce a register of patients aged 18 years and over with CKD (US National Kidney Foundation: Stage 3 to 5 CKD)	6	
Initial Management		
CKD2: The percentage of patients on the CKD register whose notes have a record of blood pressure in the previous 15 months	6	40-90%
Ongoing Management		
CKD3: The percentage of patients on the CKD register in whom the last blood pressure reading, measured in the previous 15 months, is 140/85 or less	11	40-70%
CKD5: The percentage of patients on the CKD register with hypertension and proteinuria who are treated with an angiotensin converting enzyme inhibitor (ACE-I) or angiotensin receptor blocker (ARB) (unless a contraindication or side effects are recorded)	9	40-80%
CKD6: The percentage of patients on the CKD register whose notes have a record of a urine albumin: creatinine ratio (or protein:creatinine ratio) test in the previous 15 months	6	40-80%

Chronic Kidney Disease – Rationale for Inclusion of Indicator Set

The international classification developed by the US National Kidney Foundation describes five stages of chronic kidney disease using an estimated glomerular filtration rate (eGFR) to measure kidney function (table 1). People with CKD stages three to five have, by definition, less than 60 per cent of their kidney function. Stage three is a moderate decrease in GFR with or without other evidence of kidney damage. Several groups (NICE, SIGN, UK Consensus) have recommended splitting stage 3 into 3A and 3B (table 1). Stage four is a severe decrease in GFR with or without other evidence of kidney damage and stage five is established renal failure. The QOF indicator set refers to people with stage 3 to 5 CKD.

CKD is a long-term condition; the most recent population data from the National Health and Nutrition Examination Survey (NHANES 1999-2004) suggests that the age standardised prevalence of stage 3 to 5 CKD in the non-institutionalised American population is approximately 6%³². The prevalence in females was higher than in males (6.9 versus 4.9%). In the fully adjusted model, the prevalence of low GFR was strongly associated with diagnosed diabetes (OR, 1.54; 95% CI, 1.28-1.80) and hypertension (OR, 1.98; 95% CI, 1.73-2.67) as well as higher BMI (OR, 1.08; 95% CI, 1.02-1.15 per 5-unit increment of BMI).

³² Coresh et al JAMA. 2007;298(17):2038-2047

In the UK the prevalence of CKD stage 3–5 was 8.5% and was higher in females, 10.6% in females versus 5.8% in males³³. The Association of Public Health Observatories has modelled the prevalence of CKD for England and Wales based on the results of the study by Stevens et al.

(<http://www.apho.org.uk/resource/item.aspx?RID=54378>) and report a population prevalence of 8.9%.

The NHS Information Centre reports a prevalence of CKD for 2006/7 of 2.4% using QMAS returns (http://www.ic.nhs.uk/webfiles/QOF/2006-07/QOF0607_Practice%20Prevalence.xls) suggesting that, to date, CKD is under-reported in English GP practices.

Stage	GFR*	Description	Included in QOF
1	90+	Normal kidney function but urine findings or structural abnormalities or genetic trait point to kidney disease	No
2	60-89	Mildly reduced kidney function, and other findings (as for stage 1) point to kidney disease	No
3	30-59	Moderately reduced kidney function Subdivided into 3A (45 to 59) and 3B (30 to 44)	Yes
4	15-29	Severely reduced kidney function	Yes
5	<15	Very severe, or established kidney failure	Yes

Table 1: Estimated glomerular filtration rate (eGFR) to measure kidney function

* All GFR values are normalized to an average surface area (size) of 1.73m²
Further Information: National Service Framework for Renal Services, February 2005.

www.kidney.org/professionals/kdoqi/guidelines_ckd/p4_class_g1.htm

This indicator set applies to people with stage three, four and five CKD (eGFR <60 mL/min/1.73m² confirmed with at least two separate readings over a three month period).

This indicator set applies to people with stage three, four and five CKD (eGFR <60 mL/min/1.73m² confirmed with at least two separate readings over a three month period).

CKD may be progressive; prevalence increases with age and female sex but progression increases with male sex, and South Asian and African Caribbean ethnicity. People of South Asian origin are particularly at risk of having both diabetes and CKD.. Diabetes is more common in this community than in the population

³³ Stevens et al. Kidney International 2007; 72: 92-9

overall. People of African and African Caribbean origin have an increased risk of CKD linked to hypertension.

Only a minority of people with stage one or two CKD go on to develop more advanced disease and symptoms do not usually appear until stage four. Where eGFR has persistently been recorded below 60 (<60) the CKD (stage 3) label should continue to apply, even if future management may lead to an improvement in eGFR. Early identification of CKD is important as it allows appropriate measures to be taken not only to slow or prevent the progression to more serious CKD but also to combat the major risk of illness or death due to cardiovascular disease. The presence of proteinuria is a key risk multiplier at all stages of CKD and CKD is an independent risk factor for cardiovascular disease and a multiplier of other risk factors (Wali and Henrich. *Cardiol Clin* 2005; 23(3): 343-62).

NICE guidance, early identification and management of Chronic Kidney Disease in adults in primary and secondary care was published in September 2008.

<http://www.nice.org.uk/CG73>

SIGN Guideline 103 Diagnosis and management of CKD in adults was published in June 2008.

<http://www.sign.ac.uk/guidelines/fulltext/103.index.html>

These indicators reflect both of the guidance documents:.

- Albumin-creatinine ratio (ACR) is the preferred measure of proteinuria
- NICE suggests BP should be kept below 140 (systolic) and 90 (diastolic) with a target for systolic of between 120 and 139 mmHg. There is a tougher standard for diabetes. This compares with a BP audit standard of 145/85 in this guidance for 40 to 70% of the CKD population.
- NICE recommends that the use of ACE inhibitors when there is hypertension and an ACR of ≥ 30 mg/mmol. However, when ACR ≥ 70 mg/mmol NICE recommends ACE inhibitors even in the absence of hypertension. As with BP there are stricter standards in diabetes.
- NICE divides stage 3 into Stage 3a and 3b. They recommend testing for bone disease and anaemia in Stage 3b (eGFR 30 to 44), as well as stages 4 and 5.
- NICE also recommends addition of the suffix (p) to denote significant proteinuria, defined as an ACR ≥ 30 mg/mmol (PCR ≥ 50 mg/mmol).

The QOF indicators are likely to converge with NICE guidance over coming years.

Chronic Kidney Disease (CKD) Indicator 1

The practice can produce a register of patients aged 18 years and over with chronic kidney disease (US National Kidney Foundation: Stage 3 to 5 CKD).

Chronic Kidney Disease 1.1 Rationale

Patients aged 18 years and over with a persistent estimate GFR or GFR of $<60\text{ml/min/1.73m}^2$ should be included in the register. From 2006, eGFR has been reported automatically when serum creatinine concentration is measured. Studies of general practice computerised medical records show that it is feasible to identify people with CKD (de Lusignan et al. Fam Pract 2005; 22(3): 234-41) and that computer records are a valid source of data (Anandarajah et al. Nephrol Dial Transplant 2005; 20(10): 2089-96).

The compilation of a register of people with CKD will enable appropriate advice, treatment and support for the patient to preserve kidney function and to reduce the risk of cardiovascular disease.

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

Chronic Kidney Disease 1.2: Reporting and Verification

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

Chronic Kidney Disease (CKD) Indicator 2

The percentage of patients on the CKD register whose notes have a record of blood pressure in the previous 15 months.

Chronic Kidney Disease 2.1: Rationale

Studies show that reducing blood pressure in people with CKD reduces the deterioration of their kidney function whether or not they have hypertension or diabetes. (Jafar et al. Ann Int Med 2003; 139: 244-52).

Chronic Kidney Disease 2.2: Reporting and Verification

Practices report the percentage of patients on its CKD register who have had a blood pressure measurement recorded in the previous 15 months.

Chronic Kidney Disease (CKD) Indicator 3

The percentage of patients on the CKD register in whom the last blood pressure reading, measured in the previous 15 months, is 140/85 or less

Chronic Kidney Disease 3.1 Rationale

Studies have shown that in people over 65 years and in people with diabetes, normal blood pressure is hard to achieve but is important (Anderson et al. American Journal of Kidney Disease 2005; 45(6): 994-1001).

See also the latest British Hypertension Society guidelines 2004: Williams et al. J Hum HT 2004; 18: 139-185 (specific renal advice on pages 166-7). This suggests an

“optimal” BP target in CKD of 130/80 or 127/75 if >1 g proteinuria. These targets in turn are derived from the Modification of Diet in Renal Disease study, (Klahr et al. NEJM 1994; 330: 877-884; Peterson et al. Ann Int Med 1995; 123: 754-762).

In practice, these targets are often hard to achieve and the indicator’s 40% to 70% audit standard reflects this. The lower the blood pressure achieved the better for patient care; 140/85 mm Hg is used here as an audit standard for this indicator.

<http://www.nice.org.uk/Guidance/CG73>

<http://www.sign.ac.uk/guidelines/fulltext/103/index.html>

Chronic Kidney Disease 3.2: Reporting and Verification

The practice reports the percentage of patients on its CKD register whose last recorded blood pressure measurement is 140/85 mm Hg or less. This reading should have been in the previous 15 months.

Chronic Kidney Disease (CKD) Indicator 5

The percentage of patients on the CKD register with hypertension and proteinuria who are treated with an angiotensin converting enzyme inhibitor (ACE-I) or angiotensin receptor blocker (ARB) (unless a contraindication or side effects are recorded).

Chronic Kidney Disease 5.1 Rationale

ACE inhibitors and ARBs are generally more effective than other anti-hypertensives in minimising deterioration in kidney function and this effect is most marked where there is significant proteinuria. Such treatment is both clinically and cost effective (Kent et al JASN 2007; 18: 1959-1965.). See also: Lewis et al. NEJM 1993; 329:1456-1462; Brenner et al. NEJM 2001; 345:861-869; Ruggenenti et al. Lancet 1999; 354: 359-364).

The gold standard test for measuring proteinuria is a 24-hour urine collection; though problems with timing and completeness make this an impractical test to use in general practice. The alternatives are to test the albumin-creatinine ratio (ACR) or protein-creatinine ratio (PCR) in the urine or to use a simple stick test.

SIGN Guidance also recommends measuring proteinuria with ACR in patients with diabetes and TPCR in non-diabetic patients, reflecting the differing evidence base for these two patient populations whereas recent NICE guidance has suggested that the ACR should be used in all patients

<http://www.nice.org.uk/Guidance/CG73>

<http://www.sign.ac.uk/guidelines/fulltext/103/index.html>

Thus, patients with non-diabetic stage 3 to 5 CKD should have an annual test of proteinuria ideally using ACR, or PCR according to local guidance. People with diabetes already have an annual micro-albuminuria test.

A systematic review has shown that investigation for infection of asymptomatic people with one “+” or more of is not indicated³⁴. Practitioners should only go on to send off a mid-stream urine or perform another test to look for infection if there are symptoms.

It is not possible to derive a simple correction factor that allows the conversion of ACR values to PCR or 24 hour urinary protein excretion rates because the relative amounts of albumin and other proteins will vary depending on the clinical circumstances; however, the following table of approximate equivalents will allow clinicians unfamiliar with ACR values to see the approximate equivalent PCR and 24 hour urinary protein excretion rates (Table 2).

Albumin:creatinine ratio (mg/mmol)	Protein:creatinine ratio (mg/mmol)	24 hour urinary protein excretion (g/day)
30	50	0.5
70	100	1

Table 2: Approximate equivalent ACR, PCR and 24 hour urinary protein excretion

Reference: <http://www.nice.org.uk/Guidance/CG73>

Chronic Kidney Disease 5.2 Reporting and Verification

The practice reports the percentage of patients on its CKD register with hypertension and proteinuria whose records show they have been prescribed an angiotensin converting enzyme inhibitor (ACE-I) or an angiotensin receptor blocker (ARB) in the previous six months.

Chronic kidney disease (CKD) indicator 6

The percentage of patients on the CKD register whose notes have a record of a urine albumin: creatinine ratio (ACR) or protein: creatinine ratio (PCR) test recorded in the previous 15 months

Chronic kidney disease 6.1 Rationale

Quantitative measurement of proteinuria will enable appropriate management of patients with CKD. There is good observational evidence linking proteinuria to adverse outcome³⁵.

NICE recommends the use of ACE inhibitors when there is hypertension and an ACR of $\geq 30\text{mg/mmol}$. When $\text{ACR} \geq 70\text{mg/mmol}$ NICE recommends ACE inhibitors are prescribed; even in the absence of hypertension.

³⁴ Carter JL et al Nephrol Dial Transplant. 2006 Nov; 21(11):3031-7

³⁵ Foster M. Arch Intern Med. 2007; 167(13):1386–92. Hallan S. Arch Intern Med. 2007; 167(22):2490–2496. Cirillo M. Arch Intern Med. 2008; 168(6):617–24. Brantsma A, J. Am Soc Nephrol. 2008; 19(9):1785-91

SIGN recommends the use of ACE inhibitors and/or ARBs as agents of choice in patients with proteinuria $>0.5\text{g/day}$ (approximately equivalent to a PCR of $>50\text{mg/mmol}$).

As with BP there are stricter standards for those with diabetes; ACR $>2.5\text{mg/mmol}$ in men and $>3.5\text{mg/mmol}$ in women – with or without hypertension.

<http://www.nice.org.uk/Guidance/CG73>

<http://www.sign.ac.uk/guidelines/fulltext/103/index.html>

Chronic kidney disease 6.2 Reporting and verification

The practice reports the percentage of patients on its CKD register who have an ACR or PCR test recorded in the previous 15 months.

Atrial Fibrillation

Indicator	Points	Payment Stages
Records		
AF1: The practice can produce a register of patients with atrial fibrillation.	5	
Initial diagnosis		
AF4: The percentage of patients with atrial fibrillation diagnosed after 1 April 2008 with ECG or specialist confirmed diagnosis.	10	40-90%
Ongoing management		
AF3: The percentage of patients with atrial fibrillation who are currently treated with anti-coagulation drug therapy or an anti-platelet therapy.	12	40-90%

Atrial Fibrillation- Rationale for Inclusion of Indicator Set

Atrial fibrillation is common, and an important cause of morbidity and mortality. The age specific prevalence of atrial fibrillation is rising, presumably due to improved survival of people with coronary heart disease (the commonest underlying cause of AF (Psaty et al. Circulation 1997; 96: 2455-61). One percent of a typical practice population will be in AF; 5 per cent of over 65s, and 9 per cent of over 75s. Atrial fibrillation is associated with a five fold increase in risk of stroke (Wolf et al. Stroke 1991; 22: 983-88).

<http://www.sign.ac.uk/guidelines/fulltext/94/index.html>

Atrial Fibrillation (AF) Indicator 1

The practice can produce a register of patients with atrial fibrillation

AF 1.1 Rationale

This is good professional practice and is consistent with other clinical domains within the QOF as a building block for further evidence based interventions. A register makes it possible to call and recall patients effectively to provide systematic care and to audit care. A register should include all people with an initial event; paroxysmal; persistent and permanent AF.

AF 1.2: Reporting and Verification

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

Atrial Fibrillation (AF) Indicator 4

The percentage of patients with atrial fibrillation diagnosed after 1 April 2008 with ECG or specialist confirmed diagnosis

AF 4.1: Rationale

AF is historically too often inaccurately coded. Patients with an irregular pulse have been given an AF code even though the accuracy of AF diagnosed in this way is only approximately 30 per cent. The introduction of this indicator will enable the compilation of a more accurate register and help to ensure that treatments are targeted more appropriately.

The act of referral for a specialist opinion (e.g. cardiology out patient or ECG technician report) is insufficient to achieve this indicator.

AF 4.2: Reporting and Verification

The practice reports those patients with atrial fibrillation diagnosed after 1 April 2008 who have had an ECG or been diagnosed by a specialist within 3 months of being added to the register. The practice may also report patients who have been diagnosed or had an ECG up to three months before being added to the register.

Atrial Fibrillation (AF) Indicator 3

The percentage of patients with atrial fibrillation who are currently treated with anti-coagulant drug therapy or an anti-platelet drug therapy

AF 3.1: Rationale

There is strong evidence that stroke risk can be substantially reduced by warfarin (approximately 66 per cent risk reduction)³⁶ and less so by aspirin (approximately 22 per cent risk reduction)³⁷. Warfarin in particular is under-used for stroke prevention in AF. A NICE costing report accompanying the recommendations for AF treatment in 2006³⁸ estimated that nationally 355,312 patients with AF should be on warfarin (i.e. all of those assessed as high risk, half of those at moderate risk, and none of those at low risk, using the NICE stroke risk stratification algorithm, and if not contraindicated), or an additional 165,946 patients who were not receiving this treatment – almost 50% of those estimated as requiring warfarin. Thus there is clearly a need to encourage the use of this treatment for AF patients at high risk of stroke. Furthermore, recent evidence from the BAFTA trial³⁹ and the ACTIVE-W⁴⁰ study suggests not only is warfarin much more effective than aspirin, but that it is not as unsafe – in terms of risk of serious haemorrhage - as previously thought (though it would be useful to ascertain if these findings are replicated elsewhere using an appropriate meta-analysis).

³⁶ Atrial Fibrillation Investigators. Risk Factors for stroke and efficacy of antithrombotic therapy in atrial fibrillation: analysis of pooled data from five randomized clinical trials. *Arch Intern Med.* 1994; 154: 1949-1957.

³⁷ Antithrombotic Trialists' Collaboration. Collaborative meta-analysis of randomised trials of antiplatelet therapy for prevention of death, myocardial infarction, and stroke in high risk patients. *BMJ.* 2002 Jan 12;324(7329):71-86.

³⁸ Atrial fibrillation. The management of atrial fibrillation costing report. NICE 2006.

³⁹ Mant J, Hobbs FDR, Fletcher K, Roalfe A, Fitzmaurice D, Lip GYH, Murray E. Warfarin versus aspirin for stroke prevention in an elderly community population with atrial fibrillation (the Birmingham Atrial Fibrillation Treatment of the Aged Study, BAFTA): a randomised controlled trial. *Lancet* 2007; 370: 493-503.

⁴⁰ Healey JS, Hart RG, Pogue J, Pfeffer MA, Hohnloser SH, De Caterina R, Flaker G, Yusuf S, Connolly SJ. Risks and Benefits of Oral Anticoagulation Compared With Clopidogrel Plus Aspirin in Patients With Atrial Fibrillation According to Stroke Risk: The Atrial Fibrillation Clopidogrel Trial with Irbesartan for prevention of Vascular Events (ACTIVE-W). *Stroke.* 2008; 39: 1482-1486.

Nevertheless, a significant proportion of AF patients – depending on the particular risk stratification scheme selected this can be the majority of people with AF - are not considered to be at high risk of stroke, though clearly this does not mean their risk of stroke is non-existent. Therefore, any treatment indicator (or set of indicators) should not focus solely on the high risk group, if that means the large group considered at moderate risk (or even those at low risk) are then excluded from their treatment being monitored. The NICE atrial fibrillation guidelines⁴¹ suggest that for those at moderate risk, ‘anticoagulation or antiplatelet therapy should be prescribed depending upon patient preference after discussion of risks and benefits’. This guidance therefore enables the clinician and patient to decide on the preferred regime, taking risks and benefits of both treatments (i.e. anticoagulant and antiplatelet therapy) into account, for all AF patients, whatever their category of stroke risk

NICE Grade A evidence.

Anti-coagulation or anti-platelet therapy would not necessarily be indicated if the episode of AF was an isolated event that was not expected to re-occur (e.g. one off AF with a self-limiting cause).

For the purposes of the QOF, acceptable anti-coagulation agents are warfarin and phenindione, acceptable anti-platelet agents are aspirin, clopidogrel and dipyridamole.

AF 3.2: Reporting and Verification

Practices report the percentage of patients with AF whose records show they have been prescribed anti-coagulant or anti-platelet drug therapy in the previous six months.

⁴¹ Atrial Fibrillation National Clinical Guideline for Management in Primary and Secondary Care. Royal College of Physicians 2006.

Obesity

Indicator	Points	Payment Stages
Records		
OB1: The practice can produce a register of patients aged 16 and over with a BMI greater than or equal to 30 in the previous 15 months.	8	

Rationale for Inclusion of Indicator Set

The prevalence of obesity in the United Kingdom is at least 21 per cent in men and 23.5 per cent in women and looks set to continue to rise (Forecasting obesity to 2010, Department of Health, 2006

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_4138630).

There is a substantive evidence base on the epidemiology of obesity and its association with poor clinical outcomes. In addition to the obvious associated disease burden such as inactivity, degenerative joint disease, lower employment and mood disorders, obesity is also a major contributory factor for some of the commonest causes of death and disability in developed economies, most notably greater rates of diabetes mellitus (Sullivan et al. Diabetes Care 2005; 28 (7): 1599-603) and accelerated onset of cardiovascular disease (Gregg et al. JAMA 2005; 293 (15): 1868-74). Obesity has therefore become a major health issue for the United Kingdom. The Foresight UK Tackling Obesities report 2007 estimated the cost to the UK of obesity to be £50b in 2050 at today's prices.

<http://www.foresight.gov.uk/Obesity/Obesity.html>

Obesity (OB) Indicator 1

The practice can produce a register of patients aged 16 and over with a BMI greater than or equal to 30 in the previous 15 months

OB 1.1 Rationale

This register is prospective. It is envisaged that it will include, all people whose body mass index (BMI) has been recorded in the practice as part of routine care. It is expected that this data will inform public health measures.

OB1.2 Reporting and Verification

Practices should report the number of patients on its obesity register and the number of patients with obesity as a proportion of total list size.

Learning Disabilities

Indicator	Points	Payment Stages
Records		
The practice can produce a register of patients with learning disabilities	4	

Rationale for Inclusion of Indicator Set

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

Further information:

Valuing People: a new strategy for learning disability in the 21st century. London, Department of Health, 2001.

www.archive.official-documents.co.uk/document/cm50/5086/5086.pdf

‘The Same as You?’ Scottish Executive (2000)

www.scotland.gov.uk/topics/health/care/VAUnit/Thesameasyou

NHS Health Scotland; Health Needs Assessment Report: People with Learning Disabilities in Scotland (2004)

www.healthscotland.com/uploads/documents/LD_summary.pdf

Northern Ireland Strategy on Learning Disability

<http://www.rmhdni.gov.uk/>

Learning Disability Strategy Section 7 Guidance on Service Principles and Service Responses, Welsh Assembly Government, 2004

www.wales.nhs.uk/sites3/Documents/480/SP_response_guide-e.pdf

Learning Disability (LD) Indicator 1

The practice can produce a register of patients with learning disabilities

LD 1.1 Rationale

The idea of a learning disability register for adults in primary care has been widely recommended by professionals and charities alike (See Treat Me Right, Mencap, 2004; www.mencap.org.uk).

Learning disability is defined in Valuing People (and ‘The Same as You’) as the presence of:

- A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with:

- a reduced ability to cope independently (impaired social functioning);
- which started before adulthood (18 years), with a lasting effect on development.

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

The definition does not include all those people who have a “learning difficulty”.

For most people, there is no difficulty in reaching a decision whether they have a learning disability or not. However, in those individuals where there is some doubt about the diagnosis and the level of learning disability, referral to a multidisciplinary team may be necessary to assess the degree of disability and diagnose any underlying condition. Locality learning disability teams have expanded and these, working along with Primary Care Organisations, have provided expertise and data about and for people with learning disabilities. Learning Disabilities nurses from the community learning disability team are thus likely to know the names of patients and the practice with whom they are registered and may also be able to assist in the construction of a primary care database (see Martin and Martin. *Journal of Learning Disabilities*, 2000; 4(1): 37-48).

Further information:

www.bild.org.uk/05downloads.htm#bfs

Public Health Institute of Scotland’s Autistic Spectrum Disorder: Needs Assessment Report (2001)

<http://www.scotland.gov.uk/Publications/2006/02/28094616/0>

The creation of a full register of patients aged 18 years and over with learning disabilities will provide primary care practitioners with the first important building block in providing better quality and more appropriate services for this patient population.

LD1.2 Reporting and Verification

Practices report the number of patients aged 18 years and over on its learning disability register and the number of patients with learning disabilities as a proportion of total list size.

Smoking

Indicator	Points	Payment Stages
Ongoing management		
Smoking 3: The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the previous 15 months.	30	40-90%
Smoking 4: The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who smoke whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered within the previous 15 months	30	40-90%

Smoking Indicator 3

The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the previous 15 months.

Smoking 3.1- Rationale

1. CHD.

Smoking is known to be associated with an increased risk of coronary heart disease.

Reference SIGN Guideline 97; European Task Force European Society of Cardiology

Further Information:

<http://www.sign.ac.uk/guidelines/fulltext/97/index.html><http://www.escardio.org/Pages/index.aspx>

<http://www.escardio.org/guidelines-surveys/esc-guidelines/pages/cvd-prevention.aspx>

2. Stroke/TIA.

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

Grade C Recommendation SIGN 108

Further information:

www.sign.ac.uk/pdf/sign13.pdf

3. Hypertension.

The British Hypertension Society recommends that all patients with hypertension should have a thorough history and physical examination and a smoking history is taken.

British Hypertension Society Guidelines 2004

Further information: Journal of Human Hypertension 2004; 18(3): 139 –185.

http://www.bhsoc.org/Latest_BHS_management_Guidelines.stm

Formal estimation of CHD risk should be undertaken See new indicator set cardiovascular disease primary prevention.

The ASSIGN cardiovascular risk score was developed as part of the SIGN 97 process to reduce the deprivation-related underestimation of CVD risk inherent in previous Framingham based risk scores for Scottish populations. (see www.assign-score.com) and continues to be developed. It is available through a web link to practices in Scotland and encompasses deprivation related risk due to post code.

<http://www.assign-score.com/>

4. Diabetes.

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

5. COPD.

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/

6. Asthma.

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. One controlled cohort study suggested that exposure to passive smoke at home delayed recovery from an acute attack. New grade A evidence suggests that smoking reduces the benefits of inhaled steroids and this adds further justification for recording this outcome. See Tomlinson et al. Thorax 2005; 60: 282-7. There is also epidemiological evidence that smoking is associated with poor asthma control. See Price et al. Clin Exp Allergy 2005; 35: 282-287.

7. Chronic Kidney Disease. There is good evidence from observational studies that people with CKD are at increased cardiovascular risk and hence the rationale for including CKD here.

8. Schizophrenia, bipolar affective disorder or other psychoses.

People with serious mental illness are far more likely to smoke than the general population (61% of people with schizophrenia and 46% of bipolar disorder smoke compared to 33% of the general population). Premature death and smoking related diseases, such as respiratory disorders and heart disease, are however, more common among people with serious mental illness who smoke than in the general population of smokers (Seymour L. Not all in the mind; the physical health of mental health service users. Mentality 2003).

9. Non-smokers.

It is recognised that lifelong non-smokers are very unlikely to start smoking and indeed find it quite irritating to be asked repeatedly regarding their smoking status. Smoking status for this group of patients should be recorded up to and including 25 years of age.

10. Ex-smokers.

Ex-smokers should be recorded as such for three consecutive QOF years. Thereafter smoking status need only be recorded if there is a change.

It is recognised that once a patient has been an ex-smoker for more than three years they are unlikely to restart. In recognition of this practices may choose to record ex-smoking status on an annual basis for three consecutive QOF years. Thereafter smoking status need only be recorded if there is a change. In this instance QOF years should be interpreted as a 12 month period.

Smoking 3.2 Reporting and Verification

Practices report the percentage of patients on any or any combination of the named registers in whom smoking status has been recorded

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

Smoking Indicator 4

The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses 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 previous 15 months

Smoking 4.1 Rationale

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

Reference Grade B recommendation SIGN Guidelines 96/97

Further Information:

<http://www.sign.ac.uk/guidelines/fulltext/96/index.html>
www.sign.ac.uk/guidelines/fulltext/97/index.html

A number of studies have recently shown benefits from the prescription of nicotine replacement therapy or bupropion in patients who have indicated a wish to quit smoking. Further guidance is available from the National Institute for Clinical Excellence. <http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11452>

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

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

Further information on guidance and recent developments in Smoking Cessation Update 2007 NHS Health Scotland and ASH Scotland

<http://www.healthscotland.com/documents/1762.aspx>

Smoking Indicator 4.2 Reporting and Verification

Practices should report the percentage of patients on any or any combination of the named registers who smoke who have a record of having been offered smoking cessation advice in the previous 15 months.

Section 3. Organisational Domain

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)

For each indicator (x) four descriptions are given unless it is reported electronically:

X.1 Practice guidance

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

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

X.2 Written evidence

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

In summary, written evidence is categorised as follows:

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

X.3 Assessment visit

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

X.4 Assessors' guidance

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

2. Equivalence – Other Schemes

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

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

The RCGP Quality Practice Award has been approved for all Organisational Indicators in the Framework.

Records and Information

	Indicator	Points
Records 3	The practice has a system for transferring and acting on information about patients seen by other doctors out of hours	1
Records 8	There is a designated place for the recording of drug allergies and adverse reactions in the notes and these are clearly recorded	1
Records 9	For repeat medicines, an indication for the drug can be identified in the records (for drugs added to the repeat prescription with effect from 1 April 2004). Minimum Standard 80%	4
Records 11	The blood pressure of patients aged 45 and over is recorded in the preceding 5 years for at least 65% of patients	10
Records 13	There is a system to alert the out-of-hours service or duty doctor to patients dying at home	2
Records 15	The practice has up-to-date clinical summaries in at least 60% of patient records	25
Records 17	The blood pressure of patients aged 45 and over is recorded in the preceding 5 years for at least 80% of patients	5
Records 18	The practice has up-to-date clinical summaries in at least 80% of patient records	8
Records 19	80% of newly registered patients have had their notes summarised within 8 weeks of receipt by the practice	7
Records 20	The practice has up-to-date clinical summaries in at least 70% of patient records	12
Records 21	Ethnic origin is recorded for 100% of new registrations	1
Records 23	The percentage of patients aged over 15 years whose notes record smoking status in the past 27 months (payment stages 40 – 90%)	11

Records Indicator 3

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

Records 3.1 Practice guidance

Good Medical Practice for General Practitioners (2008) states that the excellent GP “can demonstrate an effective system for transferring and acting on information from other doctors about patients”. Out-of-hours reviews in England and Scotland have emphasised the importance of the effective transfer of information.

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

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

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

Records 3.2 Written evidence

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

Records 3.3 Assessment visit

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

Records 3.4 Assessors' guidance

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

Records indicator 8

There is a designated place for the recording of drug allergies and adverse reactions in the notes and these are clearly recorded

Records 8.1 Practice guidance

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

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

Records 8.2 Written evidence

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

Records 8.3 Assessment visit

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

Records 8.4 Assessors' guidance

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

Records indicator 9

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

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.

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

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

Records 9.2 Written evidence

A survey of the drugs used should be carried out. The survey should show an indication can be identified for at least 80 per cent of repeat medications commenced after 1 April 2004. (Grade A)

Records 9.3 Assessment visit

The records should be inspected.

Records 9.4 Assessors' guidance

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

Records indicator 11

The blood pressure of patients aged 45 and over is recorded in the previous five years for at least 65% 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 the previous 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 the previous 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.

Note: A logical query and dataset (business rule) is available to support this indicator.

Records Indicator 13

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

Records 13.1 Practice guidance

Good Medical Practice (2008) states that when off duty the doctor ensures there are arrangements which "include effective 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 e.g. on holiday.

Records 13.2 Written evidence

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

Records 13.3 Assessment visit

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

Records 13.4 Assessors' guidance

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

Records indicator 15

The practice has up-to-date clinical summaries in at least 60% of patient records

Records 15.1 Practice guidance

Good Medical Practice for General Practitioners (2008) states “Important information in records should be easily accessible, for example, as part of a summary”.

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

If a computer is used the practice will need to decide which Read codes to use for common conditions. It is best to use a set of codes that has been agreed within a PCO or nationally to allow comparison and exchange of data. Practices should adhere to the joint RCGP/GPC guidance on record keeping:

www.connectingforhealth.nhs.uk/systemsandservices/gpsupport/gp/docs/good_practice_guidelines.pdf/view_

Similar indicators are proposed as Records 18 and Records 20 but higher standards must be achieved.

Records 15.2 Written evidence

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

Records 15.3 Assessment visit

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

Records 15.4 Assessors’ guidance

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

Note: A logical query and dataset (business rule) is available to support the indicator.

In Scotland, manual submission of achievement continues and is reviewed by the Scottish Government and Scottish General Practitioners Committee of the BMA annually. Please refer to PCO for current information.

Records indicator 17

The blood pressure of patients aged 45 and over is recorded in the previous five years for at least 80% of patients

Records 17.1 Practice guidance

See Records 11.1.

Records 17.2 Written evidence

See Records 11.2. (Grade A)

Records 17.3 Assessment visit

See Records 11.3.

Records 17.4 Assessors' guidance

See Records 11.4.

Records indicator 18

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

Records 18.1 Practice guidance

See Records 15.1.

Records 18.2 Written evidence

See Records 15.2. (Grade A)

Records 18.3 Assessment visit

See Records 15.3.

Records 18.4 Assessors' guidance

See Records 15.4.

Records indicator 19

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

Records 19.1 Practice guidance

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

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

Records 19.2 Written evidence

A survey should be carried out of the records of newly registered patients whose notes have been received between 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 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 per cent) from the practice survey a further 20 records will be checked if appropriate.

Records indicator 20

The practice has up-to-date clinical summaries in at least 70% of patient records

Records 20.1 Practice Guidance

See Records 15.1.

Records 20.2 Written evidence

See Records 15.2. (Grade A)

Records 20.3 Assessment Visit

See Records 15.3.

Records 20.4 Assessors Guidance

See Records 15.4.

Records indicator 21

Ethnic origin is recorded for 100% of new registrations

Records 21.1 Practice guidance

The UK is an increasingly ethnically diverse society. Information on ethnicity is important because of the need to take into account culture, religion and language in providing appropriate individual care, changing legislation, the importance of providing information on ethnicity for shared care including secondary care and the need to demonstrate non-discrimination and equal outcomes.

The experience of the UK census now means that there are nationally used ethnic categories that have been thoroughly tested and that are known to be acceptable to the majority of the population.

Further information:

A practical guide to ethnic monitoring in the NHS and Social care. London, Department of Health, 2005.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4116839

National Resource Centre for Ethnic Minority Health and ISD ethnic monitoring toolkit

www.isdscotland.org/isd/files/ETHNIC%20MONITORING%20TOOL.pdf

See also Gill et al. Health Care Needs Assessment: Black and Minority Ethnic groups.
<http://www.hcna.radcliffe-oxford.com/bemgframe.htm>

It should be noted that the census codes enable the patient to refuse to divulge their ethnicity and therefore this will not affect the practice's ability to achieve 100 per cent on this indicator.

Scottish practices may wish to refer to the guidance for the 2008 Ethnicity DES Which includes the codes to be used in the 2011 census and recommended Read Codes. This is available at

[http://www.sehd.scot.nhs.uk/pca/PCA2008\(M\)12.pdf](http://www.sehd.scot.nhs.uk/pca/PCA2008(M)12.pdf)

Records 21.2 Written evidence

A survey of written records or a computer search of new registrations should be carried out to determine the percentage where ethnicity is recorded. (Grade A)

Records 21.3 Assessment Visit

A random sample of notes or computerised records of new registrations should be inspected, to confirm that ethnicity is recorded.

Records 21.4 Assessors' guidance

The practice's own survey is verified by inspecting a number of new patient registration records at the visit.

Note: A logical query and dataset (business rule) is available to support this indicator.

Records Indicator 23

The percentage of patients aged over 15 years whose notes record smoking status in the past 27 months.

Payment stages: 40-90%

Records 23.1 Practice Guidance

There is evidence that when doctors and other health professionals advise patients to stop smoking, this is effective. This indicator examines whether smoking status is recorded in the clinical record. Current smokers should be recorded as such in the previous 27 months. Non-smokers should be recorded as such in the previous 27 months up to and including 25 years of age. New patients aged 26 years and over should be recorded as non-smokers at least once

There are two ways in which a patient can be recorded as an ex-smoker. Firstly ex-smokers can be recorded as such in the previous 27 months.

It is recognised that once a patient has been an ex-smoker for more than three years they are unlikely to restart. In recognition of this practices may choose to record ex-smoking status on an annual basis for three consecutive QOF years. Thereafter

smoking status need only be recorded if there is a change. In this instance QOF years should be interpreted as a 12 month period.

Records 23.2 Written evidence

A survey of written records or a computer search of patients aged over 15 years should be carried out (surveying a minimum of 50 records), to determine the percentage where smoking habit is recorded. For current smokers this record should be in the previous 27 months. Ex-smokers should be recorded as described above. Those who have never smoked should be recorded as such in the previous 27 months up to and including 25 years of age. (Grade A)

Records 23.3 Assessment Visit

A random sample of 20 notes or computerised records of patients aged over 15 years should be inspected to confirm that smoking status is recorded **as detailed above**

Records 23.4 Assessors' guidance

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

Note: A logical query and dataset (business rule) is available to support this indicator.

Information for Patients

	Indicator	Points
Information 4	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	1
Information 5	The practice supports smokers in stopping smoking by a strategy which includes providing literature and offering appropriate therapy	2

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, 2008)

<http://www.rcgp.org.uk/PDF/Good%20Medical%20Practice%20for%20General%20Practitioners%20%5B2008%5D.pdf>

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 from 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.

The strategy does not need to be written by the practice team. A local or national protocol could be adapted for use specifically by the practice and implemented. The provision of dedicated smoking cessation services remains the responsibility of the PCO.

Information 5.2 Written evidence

There should be a practice protocol concerning smoking cessation. (Grade A)

Information 5.3 Assessment visit

Prescribing data should be reviewed, and literature available for patients who wish to quit should be examined.

Information 5.4 Assessors' guidance

The strategy should take into account current evidence in this area. Signs of implementation may be evident in the practice's prescribing data or in the patient leaflets that are used by the practice.

Education and Training

	Indicator	Points
Education 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	4
Education 5	There is a record of all practice-employed staff having attended training/updating in basic life support skills in the preceding 36 months	3
Education 6	The practice conducts an annual review of patient complaints and suggestions to ascertain general learning points which are shared with the team	3
Education 7	The practice has undertaken a minimum of twelve significant event reviews in the past 3 years which could include: <ul style="list-style-type: none"> • Any death occurring in the practice premises • New cancer diagnoses • Deaths where terminal care has taken place at home • Any suicides • Admissions under the Mental Health Act • Child protection cases • Medication errors • A significant event occurring when a patient may have been subjected to harm, had the circumstance/ outcome been different (near miss) 	4
Education 8	All practice-employed nurses have personal learning plans which have been reviewed at annual appraisal	5
Education 9	All practice-employed non-clinical team members have an annual appraisal	3
Education 10	The practice has undertaken a minimum of three significant event reviews within the last year	6

Education indicator 1

There is a record of all practice-employed clinical staff having attended training/updating in basic life support skills in the preceding 18 months

Education 1.1 Practice guidance

The primary care team members, including GPs deal with cardio-pulmonary collapse relatively rarely, but require up-to-date skills to deal with an emergency. This is best undertaken at regular intervals through practical skills-based training sessions, as it is known that these skills diminish after a relatively short time. The timescale has been set pragmatically at 18 months, although many practices offer training on a more frequent basis.

This training may be available from a variety of providers including your local

Accident and Emergency Department, BASICS, the PCO, out-of-hours co-operative, Red Cross, St John Ambulance or equivalent. It may be sufficient for one individual in the team to attend for external training and then cascade this within the team.

Further information:

Cardiopulmonary Resuscitation Guidance for Clinical Practice and Training in Primary Care (2001)

www.resus.org.uk/pages/cpatpc.htm#contents

Resuscitation Guidelines 2005 (Resuscitation Council UK)

<http://www.resus.org.uk/pages/guide.htm>

Education 1.2 Written evidence

Attendance at BLS training should be listed. (Grade B)

Education 1.3 Assessment visit

Staff should be questioned on the date of their last BLS training.

Education 1.4 Assessors' guidance

Assessors should confirm by checking the BLS attendance list that practice-employed clinical staff have attended.

Education indicator 5

There is a record of all practice-employed staff having attended training/updating in basic life support skills in the preceding 36 months

Education 5.1 Practice guidance

Although it is rare for practice non-clinical staff to have to deal with a cardio-pulmonary collapse, the situation may arise within or outwith the practice premises.

See Education 1.

The interval for training is pragmatically set at three years although many practices offer training on a more frequent basis.

Education 5.2 Written evidence

Attendance at BLS training should be listed. (Grade B)

Education 5.3 Assessment visit

Staff should be questioned on the date of their last BLS training.

Education 5.4 Assessors' guidance

Confirmation that practice non-clinical staff have attended training should be obtained by checking the BLS attendance list.

Education indicator 6

The practice conducts an annual review of patient complaints and suggestions to

ascertain general learning points which are shared with the team

Education 6.1 Practice guidance

Practices and clinicians generally find complaints stressful. It is important that the practice view complaints as a potential source for learning and for change and development.

Reports should include a summary of each complaint or suggestion and an identification of any learning points which came out of the review. It may be useful to agree at the time of each review how the learning points or areas for change will be communicated to the team; it is likely that not all team members will be involved in every review meeting for various reasons. It may also be useful to identify an individual responsible for implementing the change and monitoring its progress.

These reports may form part of the written evidence for the indicators on significant event analysis (Education 7 and Education 10).

Education 6.2 Written evidence

Reports/minutes of team meetings where learning points have been discussed should be made, with a note of the changes made as a result. (Grade A)

Education 6.3 Assessment visit

The issue of learning from complaints should be discussed with staff and 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 could include:

- **Any death occurring in the practice premises**
- **New cancer diagnoses**
- **Deaths where terminal care has taken place at home**
- **Any suicides**
- **Any patient admitted under the Mental Health Act**
- **Child Protection Cases**
- **Medication errors**
- **A significant event, occurring when a patient may have been subjected to harm, had the circumstance/outcome been different (near miss)**

Education 7.1 Practice guidance

Detail of methodology on significant event analysis is given in Education 10.

This indicator is more prescriptive in the requirement to report on specific occurrences in the practice. Clearly if certain of these events have not occurred, e.g. patient suicide, then this should be stated in the evidence.

Education 7.2 Written evidence

Each review case report must consist of a short commentary setting out the relevant history, the circumstances of the episode and an analysis of the conclusions to be drawn.

Evidence should be presented of any clinical and organisational changes resulting from the analysis of these cases. (Grade A)

Education 7.3 Assessment visit

The reviews should be discussed.

Education 7.4 Assessors' guidance

The practice should report on its analyses in a form consistent with either of the two methods described in 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 should be one of the outcomes of the appraisal system and the points allocated to this indicator have been increased to reflect this. The plan should record the agreement between appraiser(s) and appraisee on areas for further learning, how they will be achieved, who is responsible for organising them, within what timescale, and how progress will be reviewed. It may also include learning areas which have been identified as an organisational need but which have been agreed at the appraisal as an individual development area for the appraisee to take forward. This information should be recorded.

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 and the appraisal system.

Education 8.4 Assessors' guidance

Personal learning plans and the appraisal system should be discussed with practice-employed nursing staff and the person responsible for managing the appraisal system.

Education indicator 9

All practice-employed non-clinical team members have an annual appraisal

Education 9.1 Practice guidance

Appraisal is a constructive opportunity to review performance objectives, progress and skills and identify learning needs in a protected environment. The learning needs identified may be personal to the appraisee and/or organisational learning needs which the appraisee has agreed to fulfil. The outcome of the appraisal should be a written action plan agreed between appraiser and appraisee which could include a personal learning plan for the appraisee. In addition the opportunity could be taken to review and update the appraisee's job description.

Education 9.2 Written evidence

The staff appraisal system should be described. (Grade C)

Education 9.3 Assessment visit

A discussion should be held with practice-employed non-clinical staff about their experience of appraisal.

Education 9.4 Assessors' guidance

It may be useful to discuss the appraisal system with the non-clinical staff themselves, the practice manager and the GPs.

Education Indicator 10

The practice has undertaken a minimum of three significant event reviews within the last year.

Education 10.1 Practice guidance

Significant event review is a recognised methodology for reflecting on important events within a practice and is an accepted process as evidence for GMC revalidation.

Significant event analysis is not new, although its terminology may have changed. It was first known as critical event monitoring. It provides structure to an activity which anyway happens informally between health care professionals. It is the discussion of cases and events and the learning obtained through reflection and is an extension of audit activity. Discussion of specific events can provoke emotions that can be harnessed to achieve change. For it to be effective, it needs to be practised in a culture that avoids allocating blame and involves all disciplines within the practice.

The following steps are useful in introducing significant event analysis to a practice:

1. A multidisciplinary meeting to explain the concept.
2. Consideration of events which should be important to the practice but need not imply criticism of the practice or of individuals. The practice can construct a core list as a basis to stimulate discussion or it can use the one published in the RCGP Occasional Paper (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
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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
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Section under Mental Health Act

Chronic disease:	Diabetic hypoglycaemia Leg ulcer or amputation Asthma - hospitalisation Epilepsy – status epilepticus
Organisation:	Investigation received but not acted upon Breach of confidentiality Any patient complaints Upsetting of staff

3. Mechanism for identification of events.

A logbook kept at reception may be helpful or an electronic logbook held on the practice computer system. Any mechanism should allow all team members to contribute.

4. Significant events meetings.

These are generally multidisciplinary but need not be so and need to be sensitively chaired. Notes should be taken but should not include patient identification. Each attendee should be encouraged to take along at least one significant event. The meeting can choose which to discuss first and anybody can have the right to veto if that area is considered too sensitive.

The events are then discussed, first highlighting the aspects of high standard and then those standards that can be improved. A decision about the case needs to be reached. This could be:

- celebration of excellent care
- no change
- audit required
- immediate change required.

Follow-up of these decisions should be arranged and this may occur at the next significant event analysis meeting.

These reports should be laid out in a form consistent with either of the two following suggested formats:

A.

- **Description of event.** This should be brief and can be in note form.
- **Learning outcome.** This should describe the aspects which were of high standard and those which could be improved. Where appropriate it should include why the event occurred.
- **Action plan.** The decision(s) taken need to be contained in the report. The reasons for these decisions should be described together with any other lessons learned from the discussion.

B.

- What happened?
- Why did it happen?
- Was insight demonstrated?
- Was change implemented?

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 et al. How To Do It: Use facilitated case discussions for significant event auditing. BMJ 1995; 311: 315-318.

SEA guidance for Primary Care Teams: NPSA/RCGP October 2008

<http://www.npsa.nhs.uk/nrls/improvingpatientsafety/primarycare/significant-event-audit/>

Education 10.2 Written Evidence

Each case report should consist of a short commentary setting out the relevant history, the circumstances of the episode and an analysis of the conclusions to be drawn.

Evidence should be presented of any clinical and organisational changes resulting from the analysis of these cases. (Grade A)

Education 10.3 Assessment Visit

The reviews should be discussed.

Education 10.4 Assessors Guidance

The practice should report their analyses in a form consistent with either of the two following methods:

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, if possible, all team members who were stakeholders in the event in the case discussion.

Practice Management

	Indicator	Points
Management 1	Individual healthcare professionals have access to information on local procedures relating to Child Protection	1
Management 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	1
Management 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	0.5
Management 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 with the PCO	3
Management 7	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"> • A defined responsible person • Clear recording • Systematic pre-planned schedules • Reporting of faults 	3
Management 9	The practice has a protocol for the identification of carers and a mechanism for the referral of carers for social services assessment	3
Management 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	2

Management Indicator 1

Individual healthcare professionals have access to information on local procedures relating to Child Protection.

Management 1.1 Practice guidance

Awareness of the existence of local Child Protection procedures is mandatory and all healthcare professionals should be able to access a copy.

Management 1.2 Written evidence

There should be a description of how local procedures are accessed. (Grade C)

Management 1.3 Assessment visit

Access to local procedures should be demonstrated.

Management 1.4 Assessors' guidance

The assessors should check with team members what action they would take if they had reason to suspect that a child might be being abused, including which local procedures they would refer to and how.

Management Indicator 2

There are clearly defined arrangements for backing up computer data, back-up verification, safe storage of back-up tapes and authorisation for loading programmes where a computer is used.

Management 2.1 Practice guidance

The practice should have a written policy which defines who is responsible for backing up data, how it is done and how often it is done. It is good practice to keep weekly and monthly backups as well as daily backups using a rotation of back-up tapes or their equivalent. It is good practice to keep a log. Tapes should be renewed at specified intervals. Verification of backups should also be carried out at regular specified intervals, especially in paper-light or paperless practices. Tapes should be stored in a fireproof safe, with a procedure in place for back-up tapes being stored off site in order to ensure confidentiality. The policy should also define the individuals who are authorised to load new software programmes.

Management 2.2 Written evidence

There should be written policy regarding:

- backing up data and verification, including the frequency of that back-up
- storage on and off site
- authorisation to load programmes. (Grade A)

Management 2.3 Assessment visit

The back-up and loading arrangements should be demonstrated.

Management 2.4 Assessors' guidance

The arrangements for back-up, verification and storage procedures should be checked with the responsible staff member. It is important to ascertain that staff are aware of the procedure for authorisation for loading new software.

Management Indicator 3

The Hepatitis B status of all doctors and relevant practice employed staff is recorded and immunisation recommended if required in accordance with national guidance

Management 3.1 Practice guidance

Useful guidance on Hepatitis B risks and immunisation is contained in the UK Health Departments' publication "Guidance for Clinical Health Care Workers: protection against infection with blood borne viruses - recommendations of the Expert Advisory Group on AIDS and the Advisory Group on Hepatitis" (www.dh.gov.uk/assetRoot/04/01/44/74/04014474.pdf)

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 and 2004 addenda (see above reference to the website, Annex 1) states that all health care workers who perform exposure prone procedures (EPPs) should be immunised. They should have their response to the vaccine checked and non-responders to vaccination should be investigated for infection in order to minimise risk to patients. This guidance also states that workers whose Hepatitis B status is unknown should be tested before carrying out EPPs.

Immunisation provides protection in up to 90 per cent of patients vaccinated, but is not a substitute for good infection control procedures.

The BMA website provides a specimen Hepatitis B immunisation policy in the general practice staff (non medical) specimen handbook. Advice on suitable immunisation policies can also be obtained from the Occupational Health Service, which works with reference to guidelines published in “Immunisation against Infectious Disease” (see Annex 1 in the above website).

In relation to confidentiality, the BMA Website offers the following guidance:

“It is extremely important that hepatitis B infected health care workers have the same right of confidentiality as any patient seeking or receiving medical care. Occupational health notes are separate from other hospital notes and occupational health physicians are ethically and professionally obliged not to release information without the consent of the individual. There are occasions when an employer may need to be advised that a change of duties should take place, but hepatitis B status itself will not normally be disclosed without the health care worker's consent. However, where patients are, or have been, at risk of exposure to hepatitis B from an infected healthcare worker, it may be necessary in the public interest for the employer to have access to confidential information”.

Management 3.2 Written evidence

There should be evidence that the Hepatitis B status of all staff is known. (Grade C)

Management 3.3 Assessment visit

Questioning should take place on the system to check Hepatitis B status.

Management 3.4 Assessors' guidance

It should be confirmed that evidence is available that the Hepatitis B status of all doctors and relevant practice-employed staff has been recorded and that there is a mechanism for recommending (and recording any recommendation) regarding vaccination to the doctor or staff member, including checking response to vaccination.

Management Indicator 5

The practice offers a range of appointment times to patients, which as a minimum should include morning and afternoon appointments five mornings and four afternoons per week, except where agreed by the PCO.

Management 5.1 Practice guidance

In practices which operate with open surgeries, this would mean that the practice should have a range of times of availability equivalent to the appointment range in the indicator. Patients should be offered a reasonable range of appointment times, which are advertised to them. The practice's appointment system should normally offer as a minimum the range of appointments described in the practice leaflet. In remote and rural areas, for example, or in some single-handed practices, the range of appointment availability described in the indicator will not be appropriate. In these circumstances, the practice should agree its availability with the PCO and this should be advertised in the practice leaflet. Evidence that this has been agreed should be made available to the assessor.

Management 5.2 Written evidence

The practice leaflet should be scrutinised for evidence of appointment times. (Grade A)

Management 5.3 Assessment visit

The practice leaflet and appointment book should be checked.

Management 5.4 Assessors' guidance

The assessor should check that the practice advertises in the practice leaflet a range of appointment times which corresponds to the indicator. The availability of such appointments should be confirmed by looking at a randomly selected week in the appointment book/appointment system. In practices offering a more limited range of appointment availability, the practice should provide evidence that the PCO has agreed the range on offer.

Management Indicator 7

The practice has systems in place to ensure regular and appropriate inspection, calibration, maintenance and replacement of equipment including:

- A defined responsible person
- Clear recording
- Systematic pre-planned schedules
- Reporting of faults

Management 7.1 Practice guidance

The evidence for this criterion may form part of the statutory risk assessment activity which takes place under the Health and Safety at Work Regulations 1999 (Management Regulations). Comprehensive guidance on risk assessment can be found in the Health and Safety Executive's website on <http://www.hse.gov.uk/>. The website provides a free booklet "Five steps to risk assessment".

This website also contains a free leaflet "Maintaining portable electrical equipment in offices and other low risk environments". This contains guidance on the appropriate person to inspect and maintain equipment in relation to the equipment's associated risks as well as suggested intervals between inspections and maintenance. For example, a printer may be inspected and maintained by a "competent" person with enough knowledge and training, who need not be an electrician. This is only one of

several free leaflets available on the website, others may also be relevant to the individual practice's circumstances.

The schedule should clearly identify who has overall responsibility, who is the appropriate individual to inspect/maintain/calibrate each piece of equipment, the intervals between inspections and the system for reporting faults.

Management 7.2 Written evidence

Details should be given of the system to ensure regular and appropriate inspection, calibration, maintenance and replacement of equipment meeting the stated criteria. (Grade B)

Management 7.3 Assessment visit

Assessors should undertake a review of equipment requiring maintenance, and the log of inspection and maintenance.

Management 7.4 Assessors' guidance

The practice should have in place a system which includes risk assessment of equipment and a schedule of inspection, calibration and maintenance. This should include electrical equipment.

The responsible person will not always be the person actually carrying out the inspection; this should be specified in the schedule.

The intervals between inspection, calibration and maintenance will be different for various types of equipment dependent on their associated level of risk. Inspection, calibration and maintenance should be recorded.

There should be a clear system for reporting faults.

The practice should be able to provide a written record of inspection, calibration and maintenance for some randomly selected pieces of equipment. It would be useful to consider a range of equipment from small items (e.g. printer) up to larger items such as a steriliser or defibrillator.

Management Indicator 9

The practice has a protocol for the identification of carers and a mechanism for the referral of carers for social services assessment

Management 9.1 Practice guidance

The practice should have a procedure for how carers are identified and a referral protocol to social services for assessment of the carer's support needs or to other local support such as carers centre

A carer is defined as, 'someone who, without payment, provides help and support to a relative, friend or neighbour, who could not manage to stay at home without their help due to age, sickness, addiction or disability'.

The practice should remember to include any young carers who are particularly vulnerable.

Further information:

‘Focus on Carers and the NHS-identifying and supporting hidden carers. Good Practice Guide’ <http://www.carers.org/publications,185,GP.html>

BMA Guidance on Working with Carers

www.bma.org.uk/ap.nsf/Content/Carers

NHS Carer Information Strategies guidance – HDL22 (2006) (sections 3.3 and 3.10)

www.sehd.scot.nhs.uk/mels/HDL2006_22.pdf

Carers Scotland: Resource Pack for General Practice and Primary Care:

<http://www.carerscotland.org/Information/Takingcareofyourself/Resourcepackforgeneralpracticeandprimarycare>

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/. Guidance can also be found on the ACAS web site on www.acas.org.uk. The Department for Education and Skills also publishes an Equal Opportunities Ten Point Plan for Employers giving practical advice on implementing equal opportunities policies.
- Bullying and Harassment: ACAS as above.
- IHM Healthcare Management Code at www.ihm.org.uk

- IHM Diversity Group recommendations for Recruitment and Selection.
- Sickness Absence: ACAS as above, including their booklet entitled “Absence and Labour Turnover”.
- BMA guidance on managing absence at www.bma.org.uk

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Management 10.2 Written evidence

Employment policies should be recorded. (Grade B). Policies should be consistent with current legislation and indicate a date when the policy has been reviewed.

Management 10.3 Assessment visit

The procedures manual should be inspected.

Management 10.4 Assessors’ guidance

The procedures manual should contain dated copies which are made available to staff of the policies relating to their employment. It should be confirmed with employed staff that they are aware of the content of the procedures manual and its whereabouts.

Medicines Management

	Indicator	Points
Medicines 2	The practice possesses the equipment and in-date emergency drugs to treat anaphylaxis	2
Medicines 3	There is a system for checking the expiry dates of emergency drugs on at least an annual basis	2
Medicines 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)	3
Medicines 6	The practice meets the PCO prescribing adviser at least annually and agrees up to three actions related to prescribing	4
Medicines 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)	6
Medicines 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	4
Medicines 11	A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed four or more repeat medicines. Standard 80%	7
Medicines 12	A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed repeat medicines. Standard 80%	8

Medicines Indicator 2

The practice possesses the equipment and in-date emergency drugs to treat anaphylaxis

Medicines 2.1 Practice guidance

Good Medical Practice for General Practitioners (2008) states that the excellent doctor “has up-to-date emergency equipment and drugs” and anaphylaxis is one condition that may constitute an emergency in the practice premises.

Medicines 2.2 Written evidence

There is a list of equipment and drugs that the practice has available to deal with an anaphylactic emergency. (Grade C)

Medicines 2.3 Assessment visit

The appropriate equipment and drugs are inspected.

Medicines 2.4 Assessors’ guidance

The dates of emergency drugs should be checked.

Medicines Indicator 3

There is a system for checking the expiry dates of emergency drugs on at least an annual basis

Medicines 3.1 Practice guidance

Good Medical Practice for General Practitioners (2008) states that the unacceptable GP “has drugs which are out of date” and a system is required to prevent this. The system should include all emergency drugs held in the practice premises and in the doctors’ bags.

Medicines 3.2 Written evidence

The system is described. (Grade C)

Medicines 3.3 Assessment visit

A random sample of doctors’ bags and other emergency drugs is checked.

Medicines 3.4 Assessors’ guidance

All drugs should be in date and the doctors should be questioned on the system for keeping them up to date.

Medicines Indicator 4

The number of hours from requesting a prescription to availability for collection by the patient is 72 hours or less (excluding weekends and bank/local holidays)

Medicines 4.1 Practice guidance

Practices should provide a reasonably fast service for their repeat prescriptions. Details of how the practice’s system works should be contained in the practice leaflet. If the practice can deliver the service in 48 hours, another indicator is also achieved (Medicines Indicator 8).

Medicines 4.2 Written evidence

The practice leaflet or policy is available. (Grade A). The receptionists are questioned on the policy.

Medicines 4.4 Assessors’ guidance

The assessors should check that the system for issuing repeat prescriptions can be described by the receptionists and should observe it in action.

Medicines Indicator 6

The practice meets the PCO prescribing adviser at least annually and agrees up to three actions related to prescribing

Medicines 6.1 Practice guidance

If the PCO prescribing adviser is unable to visit within the year and there has been no contact with another PCO-recognised source of prescribing advice within the year, then the practice is exempt from this indicator. In that circumstance, the practice should provide written confirmation from the PCO prescribing adviser that he or she has been unable to visit within the relevant year.

Three actions agreed with the PCO prescribing adviser should be produced, or written confirmation from the PCO prescribing adviser that he or she has been unable to visit within the relevant year. (Grade A)

Medicines 6.3 Assessment visit

The actions should be discussed.

Medicines 6.4 Assessors' guidance

This indicator will be considered to have been met if the prescribing advisor and the practice have reached agreement on the action points.

Medicines Indicator 8

The number of hours from requesting a prescription to availability for collection by the patient is 48 hours or less (excluding weekends and bank/local holidays)

Medicines 8.1 Practice guidance

Patients tend to prefer a reasonably fast service for their repeat prescriptions. Details of how the practice's system works should be contained in the practice leaflet. If the practice can achieve this in 72 hours, then another indicator is achieved (Medicines Indicator 4).

Medicines 8.2 Written evidence

The practice leaflet or policy is available. (Grade A) The receptionists are questioned on the policy.

Medicines 8.4 Assessors' guidance

The assessors should check that the system for issuing repeat prescriptions can be described by the receptionists and should observe it in action.

Medicines Indicator 10

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

Medicines 10.1 Practice guidance

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

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

Medicines 10.2 Written evidence

Three actions agreed with the PCO prescribing adviser and evidence of change should be produced, and/or written support from the prescribing adviser for the reasons for not achieving change, or written confirmation from the PCO prescribing adviser that he or she has been unable to visit within the relevant year.

Medicines 10.3 Assessment visit

Actions and improvements should be discussed.

Medicines 10.4 Assessors' guidance

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

Medicines Indicator 11

A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed four or more repeat medicines
Standard 80%

Medicines 11.1 Practice guidance

Medication is by far the most common form of medical intervention. Four out of five people over 75 take a prescription medicine and 36 per cent are taking four or more (Medicines and Older People – Supplement to the National Service Framework for Older People, 2001). However, we also know that up to 50 per cent of drugs are not taken as prescribed, many drugs in common use can cause problems and that adverse reactions to medicines are implicated in 5-17 per cent of hospital admissions. Involving patients in prescribing decisions and supporting them in taking their medicines is a key part of improving patient safety, health outcomes and satisfaction with care. Medication review is increasingly recognised as a cornerstone of medicines management. It is expected that at least a Level 2 medication review will occur, as described in the Briefing Paper www.medicines-partnership.org/medication-review/room-for-review/downloads.

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

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

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

Medicines 11.2 Written Information

A survey of medication review should be undertaken. (Grade A) This could be a computerised search and print out or a survey of fifty records of patients on four or more medications.

Medicines 11.3 Assessment Visit

Inspection of records should be carried out.

Medicines 11.4 Assessors' guidance

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

Medicines Indicator 12

A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed.

Standard 80%

Medicines 12.1 Practice Guidance

See Medicines 11.1

Medicines 12.2 Written Information

See Medicines 11.2

Medicines 12.3 Assessment Visit

See Medicines 11.3

Medicines 12.4 Assessors' Guidance

See Medicines 11.4

Patient experience domain

PE Patient Experience	Points	Payment stages
<p>PE 1 Length of Consultations</p> <p>The length of routine booked appointments with the doctors in the practice is not less than 10 minutes. (If the practice routinely sees extras during booked surgeries, then the average booked consultation length should allow for the average number of extras seen in a surgery session. If the extras are seen at the end, then it is not necessary to make this adjustment).</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>	33	
<p>PE 7 Patient experience of access (1)</p> <p>The percentage of patients who, in the appropriate national survey, indicate that they were able to obtain a consultation with a GP (in England) or appropriate health care professional (in Scotland, Wales and NI) within 2 working days (in Wales this will be within 24 hours)</p>	23.5	70-90%
<p>PE 8 Patient experience of access (2)</p> <p>The percentage of patients who, in the appropriate national survey, indicate that they were able to book an appointment with a GP more than 2 days ahead</p>	35	60-90%

PE1 Length of consultations

The length of routine booked appointments with the doctors in the practice is not less than ten minutes. If the practice routinely sees extras during booked surgeries, then the average booked consultation length should allow for the average number of extras seen in a surgery session. If the extras are seen at the end, then it is not necessary to make this adjustment

For practices with only an open surgery system, the average face-to-face time spent by the GP with the patient is at least eight minutes

Practices that routinely operate a mixed economy of booked and open surgeries should report on both criteria

PE 1.1 Practice guidance

The contract includes an incentive for practices to provide longer consultations. This has been included as a proxy for many of the things that are crucial parts of general practice, yet cannot easily be measured – e.g. listening to patients, taking time,

involving patients in decisions, explaining treatments, in addition to providing high quality care for the many conditions not specifically included in the QOF.

Practices can claim this payment if their normal booking interval is 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 six 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 separate sample weeks during each year. It is not necessary to do this if fewer than a quarter of patients are seen in open surgeries and the rest of the surgeries are booked at intervals of 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

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. Practices should submit a statement to this effect (Grade A)

For other practices, claiming against this indicator, a survey carried out on two separate weeks of consultation length or a computer printout which details the average consultation length should be available. (Grade A)

PE 1.3 Assessment visit

If the practice operates an appointment system, inspection of the appointments book (whether paper or computerised) should be carried out, looking at a sample of days over the preceding year.

If the practice has submitted a survey of consultation length, this should be reviewed.

PE 1.4 Assessors’ guidance

The assessors may need to look at a number of sample days to confirm that 75 per cent of consultations have been booked at least at 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 7 Patient experience of access (1)

The percentage of patients who, in the appropriate national survey, indicate that they were able to obtain a consultation with a GP (in England) or appropriate health care professional (in Scotland, Wales and NI) within 2 working days (in Wales this will be within 24 hours).

PE 7.1 Practice guidance

This indicator, alongside PE 8, encourages and incentivises practices to improve quick and convenient access to appointments with GPs and/or health professionals for their patients. Achievement of the indicator is dependent on the results of the national survey in each UK country. The arrangements for these differ in each country and further information is available below.

England

Achievement of the indicator is measured through the national patient experience survey titled the GP patient survey. The survey is conducted by a third party polling expert, Ipsos MORI, on behalf of the Department of Health. Ipsos MORI administer the GP patient survey to contractor’s registered patients’ and results are collated for each contractor.

The survey is administered each quarter through out the financial year. The assessment of achievement of the indicator is based on annual results. This is

determined by aggregating the results data (numerators and denominators) for the questions relating to the indicator from each of the four quarterly surveys undertaken during the financial year.

Practices will want to encourage patients to respond to the survey by displaying the relevant communication materials provided by the Department of Health/Ipsos MORI. Some patients may not want to take part in the survey and practices will need to facilitate such requests in accordance with notified arrangements for patient opt outs.

A sliding scale will apply to payments between 70% and 90% in the same fashion as other thresholds in the clinical domain. Exception reporting does not apply.

Assessment visit (England only)

The results should be discussed and ways of improving patients' experience of access in the future. The Improvement Foundation provides a general source of advice to practices and PCTs over improving patient access. www.improvementfoundation.org

Assessors' guidance (England only)

It may be useful to note if patient participation is encouraged by display of the appropriate communication materials.

Scotland

In Scotland, this indicator reflects the previous 48 hour access Directed Enhanced Service which was subject to a self declaration. From 2008/9, a national survey will be conducted annually in Scotland to assess practice achievement against this indicator and PE8 for advanced booking of appointments. The survey will be administered centrally by post to a sample of registered patients from each practice and the results collated for each practice. Information on the 2008/9 survey can be accessed at:

<http://www.paymodernisation.scot.nhs.uk/gms/index.htm>

<http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/Survey>

Practices will be informed of their results by Boards and will not need to enter these onto their QMAS report.

Wales

Information for practices about the Welsh GP Patient Survey is available on the NHS Wales GMS website:

<http://www.wales.nhs.uk/sites3/page.cfm?orgid=480&pid=34662>

Northern Ireland

Information for practices about the Department of Health, Social Services and Public Safety GP Patient Survey is available on the DHSSPSNI website:

<http://www.dhsspsni.gov.uk/index/hss/pc-primary-care.htm>

PE 7.2 Written evidence

The appropriate national survey adopted in each UK country will deliver results to inform practices of their level of achievement. The precise arrangements will vary in each UK country and again this will be notified in separate guidance.

England

In England, this will be a short report from the PCT. Practices in England will not be required to enter their achievement values from this report on QMAS. PCTs will do this on practices behalf. This is because reports will not be available until following the last day of the financial year and PCTs will therefore need to use the adjustment facility to ensure correct achievement payments are made to practices.

The precise arrangements are published on the GP patient survey pages of the Department of Health website:

<http://www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/GPpatientsurvey2007/index.htm>

PE 8 Patient experience of access (2)

The percentage of patients who, in the appropriate national survey, indicate that they were able to book an appointment with a GP more than 2 days ahead.

PE 8.1 Practice guidance

This indicator, alongside PE 7, encourages and incentivises practices to improve quick and convenient access to appointments with GPs and/or health professionals for their patients. Achievement of the indicator is dependent on the results of the national survey in each UK country. The arrangements for these differ in each country and further information is available below.

England

Achievement of the indicator is measured through the national patient experience survey titled the GP patient survey. The survey is conducted by a third party polling expert, Ipsos MORI, on behalf of the Department of Health. Ipsos MORI administer the GP patient survey to contractor's registered patients' and results are collated for each contractor.

The survey is administered each quarter through out the financial year. The assessment of achievement of the indicator is based on annual results. This is determined by aggregating the results data (numerators and denominators) for the questions relating to the indicator from each of the four quarterly surveys undertaken during the financial year.

Practices will want to encourage patients to respond to the survey by displaying the relevant communication materials provided by the Department of Health/Ipsos MORI. Some patients may not want to take part in the survey and practices will need to facilitate such requests in accordance with notified arrangements for patient opt outs.

A sliding scale will apply to payments between 60 and 90% in the same fashion as other thresholds in the clinical domain. Exception reporting does not apply.

Assessment visit (England only)

The results should be discussed and ways of improving patients' experience of access in the future. The Improvement Foundation provides a general source of advice to practices and PCTs over improving patient access.

www.improvementfoundation.org

Assessors' guidance (England only)

It may be useful to note if patient participation is encouraged by display of the appropriate communication materials.

Scotland

See PE7 above

Wales

Information for practices about the Welsh GP Patient Survey is available on the NHS Wales GMS website:

<http://www.wales.nhs.uk/sites3/page.cfm?orgid=480&pid=34662>

Northern Ireland

Information for practices about the Department of Health, Social Services and Public Safety GP Patient Survey is available on the DHSSPSNI website:

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<http://www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/GPpatientsurvey2007/index.htm>

Section 5: Additional Services

For practices providing additional services the following organisational markers will apply.

Cervical Screening (CS)

	Indicator	Points
CS 1	The percentage of patients aged from 25 to 64 (in Scotland from 21 to 60) whose notes record that a cervical smear has been performed in the last five years Standard 40 – 80%	11
CS 5	The practice has a system for informing all women of the results of cervical smears	2
CS 6	The practice has a policy for auditing its cervical screening service, and performs an audit of inadequate cervical smears in relation to individual smear-takers at least every 2 years	2
CS 7	The practice has a protocol that is in line with national guidance and practice for the management of cervical screening, which includes staff training, management of patient call/ recall, exception reporting and the regular monitoring of inadequate smear rates	7

Child Health Surveillance (CHS)

	Indicator	Points
CHS 1	Child development checks are offered at intervals that are consistent with national guidelines and policy	6

Maternity Services (MAT)

	Indicator	Points
MAT 1	Ante-natal care and screening are offered according to current local guidelines	6

Contraception (SH)

	Indicator	Points
SH 1	The practice can produce a register of women who have been prescribed any method of contraception at least once in the last year, or other appropriate interval e.g. last 5 years for an IUS.	4
SH 2	The percentage of women prescribed an oral or patch contraceptive method who have also received information from the practice about long acting reversible methods of contraception in the previous 15 months. (payment stages 40 – 90%)	3
SH 3	The percentage of women prescribed emergency hormonal contraception at least once in the year by the practice who have received information from the practice about long acting reversible methods of contraception at the time of, or within one month of, the prescription. (payment stages 40 – 90%)	3

Cervical Screening (CS)

CS Indicator 1

The percentage of patients aged from 25 to 64 (from 21 to 60 in Scotland, 20 to 64 in Wales and from 20 to 65 in Northern Ireland) whose notes record that a cervical smear has been performed in the last 5 years.

Standard 40 – 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, from 20 to 64 in Wales and from 20 to 65 in Northern Ireland) who have had a cervical smear performed in the last 60 months.

This indicator differs from all the other additional service indicators in that a sliding scale will apply between 40% 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 a hysterectomy 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 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. 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 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 need to be present.

CS Indicator 7

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

CS 7.1 Practice Guidance

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

CS 7.2 Written Evidence

There should be a written policy covering the issues outlined above (Grade A).

CS 7.3 Assessment Visit

The policy should be discussed with relevant staff and the practice should demonstrate how the systems operate.

CS 7.4 Assessors Guidance

It may be necessary to ask the practice to demonstrate how its policy operates.

Child Health Surveillance (CHS)

CHS indicator 1

Child development checks are offered at intervals that are consistent with national guidelines and policy

CHS 1.1 Practice guidance

The child health surveillance programme should be based on national guidelines. It is important that the practice has a system to ensure follow-up of any identified concern and that referrals are made as appropriate.

Health for All Children 4 (Hall 4): Guidance on Implementation in Scotland

www.scotland.gov.uk/Publications/2005/04/15161325/13269

CHS 1.2 Written evidence

There should be a description of the child health surveillance programme and how concerns are followed up. (Grade C)

CHS 1.3 Assessment visit

The practice team is asked for details of child health surveillance in the practice and how concerns are followed up.

CHS 1.4 Assessors' guidance

The practice should be aware of which guidelines it has adopted. The assessors should be content that there is a process to ensure concerns are followed up.

Maternity Services

MAT Indicator 1

Anti-natal care and screening are offered according to current local guidelines

MAT 1.1 Practice guidance

Most local areas have produced guidelines, which should be adopted within the practice.

MAT 1.2 Written evidence

There should be written guidelines on ante-natal care and screening. (Grade A)

MAT 1.3 Assessment visit

The assessment should involve a description of ante-natal care, using the illustration of one case.

MAT 1.4 Assessors' guidance

The case should show that the guidance is known and is being used.

Contraception (SH)

Around 80% of (prescribed) contraception in the UK is provided in general practice.

The vast majority of practices are providing the additional service for contraception and many are also providing enhanced services including long acting reversible contraception (LARC) methods. All practices providing any level of contraception need to be able to advise women about all methods to ensure they can make an informed choice. Clinical staff in practices which are not providing all methods also need enough knowledge of these to refer appropriately those women who have chosen a method which they do not supply. Practices also should be aware of local services and local referral pathways.

<http://www.scotland.gov.uk/Resource/Doc/35596/0012575.pdf>

NHS Quality Improvement Scotland Sexual Health Services- Standards
March 2008.

[http://www.nhshealthquality.org/nhsqis/files/SEXHEALTHSERV_STANF_MA
R08.pdf](http://www.nhshealthquality.org/nhsqis/files/SEXHEALTHSERV_STANF_MA
R08.pdf)

This indicator set seeks to increase the awareness of women seeking contraceptive advice in general practices of LARC methods and thus to increase the percentage of women using these methods.⁴²

SH indicator 1

The practice can produce a register of women who have been prescribed any method of contraception at least once in the last year, or other appropriate interval e.g. last 5 years for an IUS.

SH 1.1 Rationale

General practices provide 80% of prescribed contraception in the UK. This register is applicable to all methods of contraception that have been prescribed by the practice:

- Emergency hormonal contraception
- Combined oral contraception
- Progestogen only oral contraception
- Contraceptive patch
- Contraceptive diaphragm
- Intrauterine device (IUD)
- Intrauterine system (IUS)
- Contraceptive implant

Any woman who has been prescribed any method at least once in the last year (or the appropriate prescribing interval for method of choice) should be included on the register.

This indicator is prospective from 1 April 2009.

SH 1.2 Reporting and verification

The practice reports the number of women prescribed any method of contraception in the preceding 1 April to 31 March (or longer if appropriate for the method of choice).

⁴² See also J Fam Plann Reprod Health Care 2008; 34(4): 000–000 “Attitudes of women in Scotland to contraception: a qualitative study to explore acceptability of long-acting methods” Anna Glasier, Jane Scorer, Alison Bigg.

SH indicator 2

The percentage of women prescribed an oral or patch contraceptive method who have also received information from the practice about long acting reversible methods of contraception in the previous 15 months.

SH 2.1 Rationale

A woman's contraceptive needs can change over her reproductive lifespan. Women requiring contraception should be given detailed information about and offered a choice of all methods, including LARC. This indicator seeks to encourage practices to review these needs on a regular basis and ensure that women are informed of advances in contraceptive choices.

All currently available long acting reversible contraception methods (LARC) are more cost-effective than the combined oral contraceptive even at one year of use. LARC methods include intrauterine devices, the intrauterine system, injectable contraceptives and implants. This is largely because their effectiveness is independent of patient compliance. Of the LARC methods, injectable contraceptives are the least cost effective. Increasing the uptake of LARC methods will reduce the number of unintended pregnancies. However, currently in the UK, about 8% of contraceptive users use LARC. Whilst international comparison is difficult, this percentage is very low.

Ref NICE guidance Long acting reversible contraceptives 2005

<http://www.nice.org.uk/Guidance/CG30>

Information from the practice should be written and verbal. Leaflets can be obtained from a number of sources including the fpa, a UK-wide sexual health charity, which produces an excellent range of contraception leaflets including 'Your Guide to Contraception', which, amongst other things, indicates LARC and non-LARC methods clearly through the use of shading.

See <http://www.fpa.org.uk/Information/Readourinformationbooklets/guide>

Faculty of Sexual & Reproductive Healthcare guidelines on contraceptive methods are available at www.ffprhc.org.uk.

SH 2.2 Reporting and verification

The practice reports the percentage of those women prescribed oral or transdermal contraception who have a record of having been given advice on LARC methods in the past 15 months.

Verification - Practices should be prepared to demonstrate how patients are given such advice, examples of leaflets and any specific practice protocols.

SH indicator 3

The percentage of women prescribed emergency hormonal contraception at least once in the last year by the practice, who have received information from the practice about long-acting reversible methods of contraception at the time of, or within one month of the prescription.

SH 3.1 Rationale

Women requiring emergency hormonal contraception should be given detailed information about and offered a choice of all methods, including LARC. It is often possible (and in many cases ideal practice) to commence an ongoing method of contraception at the same time as emergency hormonal contraception is given.

Some women seeking emergency contraception may be best served by being offered an emergency IUD. Emergency IUDs offer a slightly longer window period for action after unprotected intercourse than hormonal EC; they have a higher efficacy in prevention of pregnancy - and they provide excellent ongoing contraception if required.

Information from the practice should be written and verbal. Leaflets can be obtained from a number of sources however the fpa, a UK-wide sexual health charity, has an excellent range of contraception leaflets including 'Your Guide to Contraception', which, amongst other things, indicates LARC and non-LARC methods clearly through the use of shading.

See <http://www.fpa.org.uk/Information/Readourinformationbooklets/guide>

SH 3.2 Reporting and verification

Practices should report the percentage of those women prescribed emergency hormonal contraception who are recorded as having received advice on LARC methods at the time of, or within one month of the most recent script for emergency hormonal contraception.

ANNEX F

CALCULATION OF ADDITIONAL SERVICES ACHIEVEMENT POINTS

F.1 The additional services indicators do not apply to all of the contractor's registered population. Assessment of achievement is carried out in relation to particular target populations. The relevant target populations are–

- Cervical screening services: females aged 21 to 60 years
- Child health surveillance: children of both sexes under the age of 5 years
- Maternity medical services: females aged under 55 years
- Contraceptive services: females aged under 55 years

F.2 For example, to meet the requirements of the child health surveillance indicator, child health development checks will only need to be offered to the practice's registered population of children under the age of 5 years.

F.3 For each of the additional services mentioned in paragraph F.1, a Target Population Factor is to be calculated as follows -

- (a) first the number of patients registered with the contractor in the relevant target population at the start of the final quarter (**A**) is to be divided by the contractor's CRP at the start of the final quarter (**B**);
- (b) then the number of patients registered with all contractors in Scotland in the relevant target population at the start of the final quarter (**C**) is to be divided by the total number of patients registered in Scotland (according to PSD of NHS National Services Scotland) at the start of the final quarter (**D**); and
- (c) the number produced by the calculation in paragraph (a) is then to be divided by the number produced by the calculation in paragraph (b) to produce the Target Population Factor for the additional service in question.

F.4 For the purposes of paragraph F.3, the “relevant date” is the date in respect of which the value of the contractors CPI that is being used to calculate its Achievement Payment is established. Generally this is the start of the final quarter of the financial year to which the Achievement Payment relates, but see paragraph 6.7.

F.5 The Target Population Factor for the additional service is to be multiplied by £126.76 to produce the cash total in respect of the additional service (**F**).

F.6 This calculation could be expressed as–

$$\frac{(A \div B)}{(C \div D)} \times £126.76 \times E = F$$

F.7 If the contractor has not been under an obligation to provide an additional service for any period during the financial year to which the Achievement Payment relates, the adjusted total for that particular additional service is to be further adjusted by the fraction produced by dividing–

- (a) the number of days in the financial year during which its GMS contract had effect and the contractor was under an obligation to provide the additional service; by
- (b) the number of days in the financial year during which the contract had effect.

F.8 The resulting cash amounts, in respect of each additional service, are then to be added together for the total amount in respect of the additional services domain.

ANNEX G

ADJUSTED PRACTICE DISEASE FACTOR CALCULATIONS

G.1 The calculation involves three steps:

- first, the calculation of the practice's Raw Practice Disease Prevalences. There will be a Raw Practice Disease Prevalence in respect of each disease area (other than the area relating to palliative care) for which the contractor is seeking to obtain Achievement Points;
- secondly, making an adjustment to give an Adjusted Practice Disease Factor (APDF);
- thirdly, applying the factor to the pounds per point figure for each disease area (other than the area relating to palliative care).

G.2 These steps are explained below.

G.3 The Raw Practice Disease Prevalence is calculated by dividing the number of patients on the relevant disease register at 31st March in the financial year to which the Achievement Payment relates by the contractor's CRP for the relevant date. For these purposes, the "relevant date" is the date in respect of which the value of the contractor's CPI that is being used to calculate its Achievement Payment is established. Generally this is the start of the final quarter of the financial year to which the Achievement Payment relates, but see paragraph 6.7.

G.4 Subject to the provisions at G4A relating to calculations in respect of Achievement Payments relating to financial years prior to 2009/2010, the Adjusted Practice Disease Factor is calculated by:

- (a) calculating the national range of Raw Practice Disease Prevalences in Scotland (Health Boards are to use the national range established annually through the Quality and Outcomes Framework Management and Analysis System (QMAS)) and applying a 5% cut-off at the bottom of the range. Practices below this will be treated as having the same prevalence as the cut-off point;
- (b) once the cut-off has been applied, rebasing the contractor figures around the new national Scottish mean to give the Adjusted Practice Disease Factor (APDF). For example, an APDF of 1.2 indicates a 20% greater prevalence than the mean, in the adjusted distribution. The rebasing ensures that the average contractor (i.e. one with an APDF of 1.0) receives £126.76 per point, after adjustment;

- (c) thus, adjusting via the factor the contractor's average pounds per point for each disease, rather than the contractor's points score. For example, a contractor with an APDF of 1.2 for CHD will receive £152.11 per point scored on the CHD indicators.

G.4A In respect of Achievement Payments relating to financial years prior to 2009/2010, the Adjusted Practice Disease Factor is calculated by:

- (a) calculating the national range of Raw Practice Disease Prevalences in Scotland (NHS Boards are to use the national range established annually through the Quality and Outcomes Framework Management and Analysis System (QMAS) and applying a 5% cut-off at the bottom of the range. Contractors below this will be treated as having the same prevalence as the cut-off point.
- (b) once the cut –off has been applied making a square root transformation to all the contractor prevalence figures. This means that the prevalence distribution will be compressed to a narrower range. It will prevent financial destabilisation of those with the lowest prevalence;
- (c) after the transformation, rebasing the contractor figures around the new national Scottish mean to give the Adjusted Practice Disease Factor (APDF). For example, an APDF of 1.2 indicates a 20% greater prevalence than the mean, in the adjusted distribution. The rebasing ensures that the average contractor(i.e. one with an APDF of 1.0) receives £126.76 per point after adjustment;
- (d) thus adjusting via the factor the contractor's average pounds per point for each disease rather than the contractor's points score. For example, a contractor with an APDF of 1.2 for CHD will receive £152.11 per point scored on the CHD indicators.

G.5 As a result of this calculation, each contractor will have a different 'pounds per point' figure for each disease area (other than the area relating to palliative care), and it will then be possible to use these figures to calculate a cash total in relation to the points scored in each disease area (other than the area relating to palliative care).

G.6 This national prevalence figure and range of practice prevalence will be calculated on a Scotland -only basis.

G.7 If the contractor's GMS contract terminates before 1st January in the financial year to which the Achievement Payment relates the Adjusted Practice Disease Factor to be used in calculating the contractor's Achievement Payment should be the Adjusted Practice Disease Factor calculated for the contractor for the previous financial year (and where such calculation needs to be made in respect of a GMS contract that terminates before 1st January in the financial year 2009/2010, the Adjusted Practice Disease Factor to be used for the calculation will be the previous year's Adjusted Practice Disease Factor as calculated using the square root adjustment that was applicable to such calculation). . If the contractor did not have an Adjusted

Practice Disease Factor calculation for the previous financial year then no Adjusted Practice Disease Factor should be used in calculating the contractor's Achievement Payment for that year.

G.8 If the contractor's GMS contract terminates on or after 1st January, but before 31st March, in the financial year to which the Achievement Payment relates the Adjusted Practice Disease Factor to be used in calculating the contractor's Achievement Payment for that year should be the Adjusted Practice Disease Factor calculated in accordance with paragraphs G1 to G4 above.

ANNEX H

LIST OF PRACTICES FOR WHICH ADDITIONAL PAYMENTS ARE PAYABLE UNDER THE GOLDEN HELLO SCHEME

(This is the 03/04 list, which is due to be updated for 04/05)

GP PRACTICES LOCATED ON ISLANDS IN SCOTLAND

Location	Health Board	Practice code	Address			Post code
MAIN	ORKNEY	38008	SCAPA MEDICAL GROUP	NEW SCAPA ROAD	KIRKWALL	KW151BZ
MAIN	ORKNEY	38012	SKERRYVORE PRACTICE	NEW SCAPA ROAD	KIRKWALL	KW151BZ
MAIN	ORKNEY	38027	JOHN STREET	STROMNESS	ORKNEY	KW163AD
MAIN	ORKNEY	38031	DOUNBY	ORKNEY		KW172HT
MAIN	ORKNEY	38046	GREYSTONES	EVIE ST MARGARET'S HOPE	ORKNEY	KW172PQ
MAIN	ORKNEY	38051	DAISY VILLA	HOPE	ORKNEY	KW172SN
BRANCH	ORKNEY	38051	HALL	BURRAY	ORKNEY	KW172SS
MAIN	ORKNEY	38065	HEATHERLEA	EDAY NORTH	ORKNEY	KW172AB
MAIN	ORKNEY	38070	NEW MANSE	RONALDSAY	ORKNEY	KW172BE
MAIN	ORKNEY	38084	BRINIAN HOUSE	ROUSAY	ORKNEY	KW172PU
BRANCH	ORKNEY	38084	EGILSAY GERAMOUNT HOUSE	ORKNEY		KW172QD
MAIN	ORKNEY	38099	HOUSE	STRONSAY	ORKNEY	KW172AE
MAIN	ORKNEY	38101	FLEBISTER HOUSE	SANDAY	ORKNEY	KW172BW
MAIN	ORKNEY	38116	ELWICKBANK HOY AND WALLS HEALTH CENTRE	SHAPINSAY	ORKNEY	KW172EA
MAIN	ORKNEY	38121		LONGHOPE	ORKNEY	KW163PA
MAIN	ORKNEY	38135	SPRINGBANK	FLOTTA	ORKNEY	KW163NP
MAIN	ORKNEY	38140	TRENABIE HOUSE	WESTRAY	ORKNEY	KW172DL
BRANCH	ORKNEY	38140	PAPA WESTRAY YELL HEALTH CENTRE	ORKNEY		KW172BU
MAIN	SHETLAND	39015		REAFIRTH	MID YELL	ZE2 9BX
BRANCH	SHETLAND	39015	CULLIVOE	YELL	SHETLAND	ZE2 9BT
BRANCH	SHETLAND	39015	BURRAVOE	YELL	SHETLAND	ZE2 9AY
BRANCH	SHETLAND	39015	NURSES HOUSE WHALSAY HEALTH CENTRE	HUBIE	FETLAR	ZE2 9DJ
MAIN	SHETLAND	39020		SYMBISTER	WHALSAY	ZE2 9PS
BRANCH	SHETLAND	39020	NURSES HOUSE HILLSWICK	SKERRIES	SHETLAND	ZE2 9AS
MAIN	SHETLAND	39034	HEALTH CENTRE BRAE HEALTH CENTRE	WEST AYRE	HILLSWICK	ZE2 9RW
MAIN	SHETLAND	39049	WALLS HEALTH CENTRE	BRAE	SHETLAND	ZE2 9QJ
MAIN	SHETLAND	39053		WALLS	SHETLAND	ZE2 9PS
BRANCH	SHETLAND	39053	SANDNESS	WALLS	SHETLAND	ZE2 9PL
BRANCH	SHETLAND	39053	SCHOOLHOUSE	PAPASTOUR	WALLS	ZE2 9PW
BRANCH	SHETLAND	39053	NURSES HOUSE	FOULA	SHETLAND	ZE2 9PN
MAIN	SHETLAND	39068	BIXTER HEALTH	BIXTER	SHETLAND	ZE2 9NA

			CENTRE			
BRANCH	SHETLAND	39068	AITH	BIXTER	SHETLAND	ZE2 9NB
BRANCH	SHETLAND	39068	SKELD	BIXTER	SHETLAND	ZE2 9NL
MAIN	SHETLAND	39072	GORD	LEVENWICK	SHETLAND	ZE2 9HX
BRANCH	SHETLAND	39072	NURSE'S HOUSE	FAIR ISLE	SHETLAND	ZE2 9JU
MAIN	SHETLAND	39087	SCALLOWAY	SHETLAND		ZE1 0UX
BRANCH	SHETLAND	39087	WEISDALE	SHETLAND		ZE2 9LQ
BRANCH	SHETLAND	39087	HAMNOVOE	BURRA	SHETLAND	ZE2 9JY
BRANCH	SHETLAND	39087	WHITENESS	SHETLAND		ZE2 9LY
BRANCH	SHETLAND	39087	BRIDGE END LERWICK HEALTH CENTRE	BURRA	SHETLAND	ZE2 9LE
MAIN	SHETLAND	39091		SOUTH ROAD	LERWICK	ZE1 0RZ
BRANCH	SHETLAND	39091	SANDWICK	SHETLAND		ZE2 9HW
BRANCH	SHETLAND	39091	CUNNINGSBURGH	SHETLAND MONTFIELD LANE		ZE2 9HB
MAIN	SHETLAND	39104	BLOCK 1 UNST HEALTH CENTRE		LERWICK	ZE1 0LF
MAIN	SHETLAND	39161		BALTASOUND	UNST	ZE2 9DY
BRANCH	SHETLAND	39161	SAXAVORD	UNST	SHETLAND	ZE2 9EF
BRANCH	SHETLAND	39161	UYEASOUND BROADFORD MEDICAL CENTRE	UNST	SHETLAND	ZE2 9DL
MAIN	HIGHLAND	55516		HIGH ROAD	BROADFORD SKYE AND LOCHALSH	IV499AA
MAIN	HIGHLAND	55521	TRIEN DUNVEGAN	CARBOST		IV478ST
MAIN	HIGHLAND	55535	HEALTH CENTRE	DUNVEGAN	ISLE OF SKYE	IV558GU
MAIN	HIGHLAND	55540	SLEAT MEDICAL PRACTICE	FERRINDONALD	SLEAT	IV448RF
MAIN	HIGHLAND	55569	CHURCH ROAD PORTREE	KYLE OF LOCHALSH		IV408DD
MAIN	HIGHLAND	55573	MEDICAL CENTRE	PORTREE	ISLE OF SKYE	IV519BZ
MAIN	HIGHLAND	55677	GRIANAN	ISLE OF EIGG	LOCHABER	PH424RL
MAIN	AYRSHIRE & ARRAN	80645	BRODICK HEALTH CENTRE	BRODICK	ARRAN	KA278AJ
MAIN	AYRSHIRE & ARRAN	80650	LAMLASH	ARRAN		KA278NS
BRANCH	AYRSHIRE & ARRAN	80650	BRODICK CLINIC	INVERCLOY	BRODICK	KA278AJ
BRANCH	AYRSHIRE & ARRAN	80650	VILLAGE HALL	KILMORY	ARRAN	KA278PQ
BRANCH	AYRSHIRE & ARRAN	80650	WHITING BAY CLINIC	ARNHALL LODGE	WHITING BAY	KA278PX
MAIN	AYRSHIRE & ARRAN	80664	SHISKINE CLINIC	INGLEWOOD	SHISKINE	KA278EW
BRANCH	AYRSHIRE & ARRAN	80664	VILLAGE HALL	KILMORY	ARRAN	KA278PX
BRANCH	AYRSHIRE & ARRAN	80664	NEWTON ROAD	LOCHRANZA	ARRAN	KA278HQ
BRANCH	AYRSHIRE & ARRAN	80664	COMMUNITY CENTRE	PIRNMILL	ARRAN	KA278JU
MAIN	AYRSHIRE & ARRAN	80679	10 KELBURN STREET	MILLPORT		KA280DT
BRANCH	ARGYLL & CLYDE	84006	PUBLIC HALL	ISLE OF LISMORE	ARGYLL	PA345UG
MAIN	ARGYLL & CLYDE	84097	ARINAGOUR	ISLE OF COLL		PA786SY
MAIN	ARGYLL & CLYDE	84129	BENORAN	ISLE OF COLONSAY		PA617YW
MAIN	ARGYLL & CLYDE	84331	WINDSOR	MAIN STREET	BOWMORE	PA437JH
MAIN	ARGYLL & CLYDE	84345	GEIRHILDA	BACK ROAD	PORT ELLEN	PA427DL
MAIN	ARGYLL & CLYDE	84350	THE RHINNS MEDICAL CENTRE	PORT CHARLOTTE	ISLE OF ISLAY	PA487UD
MAIN	ARGYLL & CLYDE	84383	GLENCAIRN GP SURGERY	CRAIGHOUSE	ISLE OF JURA	PA607XG

BRANCH	ARGYLL & CLYDE	84472	ARDMINISH	ISLE OF GIGHA		PA417AB
MAIN	ARGYLL & CLYDE	84504	SALEN SURGERY	PIER ROAD	SALEN AROS	PA726JL
MAIN	ARGYLL & CLYDE	84519	ROCKFIELD ROAD	TOBERMORY	ISLE OF MULL	PA756PN
MAIN	ARGYLL & CLYDE	84523	BUNESSAN	ISLE OF MULL		PA676DG
BRANCH	ARGYLL & CLYDE	84523	ISLE OF IONA ROTHESAY			PA766SJ
MAIN	ARGYLL & CLYDE	84646	HEALTH CENTRE	HIGH STREET	ROTHESAY	PA209JL
MAIN	ARGYLL & CLYDE	84805	BAUGH HOUSE GP SURGERY	SCARINISH	ISLE OF TIRREE	PA776UN
MAIN	WESTERN ISLES	90007	GEARRA MOR SURGERY	BORVE	ISLE OF LEWIS	HS2 0RX
BRANCH	WESTERN ISLES	90007	HABOST CLINIC	NESS	ISLE OF LEWIS	HS2 0TG
			SHAWBOST SECONDARY SCHOOL			
BRANCH	WESTERN ISLES	90007	SCHOOL	SHAWBOST	ISLE OF LEWIS	HS2 9BQ
MAIN	WESTERN ISLES	90026	CARLOWAY DISTRICT NURSE'S	ISLE OF LEWIS		HS2 9AG
BRANCH	WESTERN ISLES	90026	COTTAGE	BREASCLETE	ISLE OF LEWIS	HS2 9EF
MAIN	WESTERN ISLES	90031	STORNOWAY HEALTH CENTRE	SPRINGFIELD ROAD	STORNOWAY	HS1 2PS
BRANCH	WESTERN ISLES	90031	CEILIDH HOUSE	NORTH TOLSTA	ISLE OF LEWIS	HS2 0NG
MAIN	WESTERN ISLES	90045	STORNOWAY HEALTH CENTRE	SPRINGFIELD ROAD	STORNOWAY	HS1 2PS
BRANCH	WESTERN ISLES	90045	CEILIDH HOUSE	NORTH TOLSTA	ISLE OF LEWIS	HS2 0NG
			ARCHWAY MEDICAL PRACTICE			
MAIN	WESTERN ISLES	90050		16 FRANCIS STREET	STORNOWAY	HS1 2XB
MAIN	WESTERN ISLES	90064	MIAVAIG THE NURSE'S	VIG	ISLE OF LEWIS	HS2 9HW
BRANCH	WESTERN ISLES	90064	COTTAGE	BREASCLETE	ISLE OF LEWIS	HS2 9LT
MAIN	WESTERN ISLES	90079	GLEANN MOR	LOCHS	ISLE OF LEWIS	HS2 9JP
BRANCH	WESTERN ISLES	90079	BREASCLETE PRIMARY SCHOOL	BREASCLETE	ISLE OF LEWIS	HS2 9ED
BRANCH	WESTERN ISLES	90079	BALALLAN PRIMARY SCHOOL	BALALLAN	ISLE OF LEWIS	HS2 9PN
MAIN	WESTERN ISLES	90083	BLAR MHOR	GRAVIR	ISLE OF LEWIS	HS2 9QX
MAIN	WESTERN ISLES	90098	DOCTOR'S HOUSE	TARBERT	HARRIS	HS3 3BG
BRANCH	WESTERN ISLES	90098	THE CLINIC	SCALPAY		HS4 3XU
MAIN	WESTERN ISLES	90101	FERRY ROAD	LEVERBURGH		HS5 3UA
BRANCH	WESTERN ISLES	90101	LOCH HOUSE SURGERY	GEOCRAB	HARRIS	HS3 3HB
MAIN	WESTERN ISLES	90115	LOCHMADDY	NORTH UIST		HS6 5AE
			ALL MAIL TO BE SENT TO THE MAIN PRACTI	**AT THE SURGERY, LOCHMADDY HS6 5AE	**AND NOT TO BAYHEAD, TIGH CEILIALA**	
BRANCH	WESTERN ISLES	90115		**AT THE SURGERY, LOCHMADDY HS6 5AE**	**AND NOT TO BERNARAY NURSES COTTAGE**	
			ALL MAIL TO BE SENT TO THE MAIN PRACTI	**AT THE SURGERY, LOCHMADDY HS6 5AE	**AND NOT TO TRIANAI, CARINISH**	
BRANCH	WESTERN ISLES	90115				
MAIN	WESTERN ISLES	90120	SORELLE LODGE SURGERY	GRIMINISH	BENBECULA	HS7 5QA
BRANCH	WESTERN ISLES	90120	DALIBURGH HOSPITAL	DALIBURGH	SOUTH UIST	HS8 5SS

BRANCH	WESTERN ISLES	90120	BENBECULA COMMUNITY CLINIC SOUTH UIST MEDICAL PRACTICE	BALIVANICH	BENBECULA	HS7 5LA
MAIN	WESTERN ISLES	90134		DALIBURGH	LOCHBOISDALE	HS8 5SS
BRANCH	WESTERN ISLES	90134	ERISKAY COMMUNITY CENTRE	SOUTH VIST	SOUTH UIST	HS8 5JU
BRANCH	WESTERN ISLES	90134	CLACH MHILE SURGERY	STONEYBRIDGE	SOUTH UIST	HS8 5SD
MAIN	WESTERN ISLES	90149		CASTLEBAY	ISLE OF BARRA	HS9 5XD
BRANCH	WESTERN ISLES	90149	CHURCH HALL	NORTHBAY	BARRA	HS9 5YQ

ANNEX I

PNEUMOCOCCAL AND HIB/MENC BOOSTER VACCINATIONS AND PNEUMOCOCCAL CATCH-UP CAMPAIGN

THE PROVISIONS SET OUT BELOW ARE THE PROVISIONS CONTAINED IN ANNEX 1 AND ANNEX 2 TO THE LETTER DATED 12TH JULY 2006 FROM THE CHIEF MEDICAL OFFICER, THE CHIEF NURSING OFFICER AND THE CHIEF PHARMACEUTICAL OFFICER

Annex 1

The Routine Childhood Immunisation Programme

1. Background to the changes

The background for the changes to the routine childhood immunisation programme is detailed in our letter dated 8 February 2006 (available at [http://www.show.scot.nhs.uk/sehd/cmo/CMO\(2006\)03.pdf](http://www.show.scot.nhs.uk/sehd/cmo/CMO(2006)03.pdf)). Further information will be available in the factsheets and new green book chapters, on the NHS Health Scotland website www.healthscotland.com/immunisation and on the JCVI website www.advisorybodies.doh.gov.uk/JCVI/.

2. Timing

The routine programme will change on 4 September 2006. All children starting their immunisation from that date should be offered the new immunisation schedule. The Hib/MenC booster should also be introduced for children aged 12 months of age from that date.

3. Routine Childhood Immunisation Schedule

All children starting the immunisation programme at 2 months of age will follow the schedule below (see Table 1):

Table 1

When to immunise	What is given	Vaccine and how it is given
Two months old	Diphtheria, tetanus, pertussis, polio and <i>Haemophilus influenzae</i> type b (DTaP/IPV/Hib)	One injection (Pediacelel)
	Pneumococcal (PCV)	One injection (Prevenar)
Three months old	Diphtheria, tetanus, pertussis, polio and <i>Haemophilus influenzae</i> type b (DTaP/IPV/Hib)	One injection (Pediacelel)
	Meningitis C (MenC)	One injection (Menjugate, Neisvac C or Meningitec)
Four months old	Diphtheria, tetanus, pertussis, polio and <i>Haemophilus influenzae</i> type b (DTaP/IPV/Hib)	One injection (Pediacelel)
	Pneumococcal (PCV)	One injection (Prevenar)

	Meningitis C (MenC)	One injection (Menjugate, Neisvac C or Meningitec)
Around 12 months	<i>Haemophilus influenzae</i> type b, Meningitis C (Hib/MenC)	One injection (Menitorix)
Around 13 months	Measles, mumps and rubella (MMR)	One injection (Priorix or MMR II)
	Pneumococcal (PCV)	One injection (Prevenar)
Three years four months to five years old	Diphtheria, tetanus, pertussis and polio (dTaP/IPV or DTaP/IPV)	One injection (Infanrix-IPV or Repevax)
	Measles, mumps and rubella (MMR)	One injection (Priorix or MMR II)
Thirteen to 18 years old	Tetanus, diphtheria and polio (Td/IPV)	One injection (Revaxis)

It is important that all those involved in immunisations are familiar with the childhood immunisation schedule (described in Table 1). Changes are:

- the addition of a pneumococcal conjugate vaccine (PCV) at 2, 4 and 13 months of age;
- one dose of MenC vaccine at 3 and at 4 months;
- a booster dose of Hib and MenC vaccine (given as a combined Hib/MenC vaccine) at 12 months of age.

Introducing these changes means that:

- infants will be offered different combinations of vaccines at the 2, 3 and 4 month visits;
- three injections will be offered to infants at 4 months of age;
- a new 12 month vaccination visit will be introduced.

4. Children aged over 2 months of age at the start of the programme

There will be a small number of children who will be part-way through their primary vaccination schedule when the changes are introduced. It is important to ensure that these children receive three doses of DTaP/IPV/Hib (Pediace), and at least two doses of MenC (with one dose being given at the 4 month visit).

All children aged over 2 months and under 2 years of age will be offered PCV as part of the catch-up campaign (see Annex 2 and 3 for details).

All children, irrespective of their primary vaccination history, should receive a booster dose of Hib/MenC vaccine at their routine 12 months of age visit in order to ensure long-term protection. There is no Hib/MenC catch-up for children older than 12 months of age at the start of the new programme.

5. Children at an increased risk of pneumococcal infection

Some groups of children are at increased risk from pneumococcal infection (see Table 2).

All at-risk children will routinely be offered PCV vaccine, according to the schedule for the routine immunisation programme (i.e. at 2, 4 and 13 months of age). In addition, all at-risk children should be offered a single dose of pneumococcal polysaccharide vaccine (PPV) when they are two years of age or over.

At-risk children presenting late for immunisation

At-risk children who present late for vaccination should be offered 2 doses of PCV⁴³ before the age of 12 months and a further dose at 13 months of age. All at-risk children should also be offered a single dose of PPV when they are two years of age or older and at least 2 months after the final dose of PCV.

At-risk children aged over 12 months and under 5 years of age should be offered a single dose of PCV. Please note that children in this age group who have asplenia or splenic dysfunction, or who are immunocompromised, require a second dose of PCV because this group may have a sub-optimal immunological response to the first dose of vaccine. This should be given 2 months after the first dose. They should also be offered a single dose of PPV (if not previously given) when they are two years of age or older (and at least 2 months after the final dose of PCV).

At-risk children presenting for first pneumococcal immunisation aged 5 years and over should be offered a single dose of PPV.

6. Children under five years of age who have previously had invasive pneumococcal disease

All children under 5 years of age, who have had invasive pneumococcal disease (IPD), for example pneumococcal meningitis or pneumococcal bacteraemia, should be offered a dose of PCV irrespective of previous vaccination history. Children under 13 months who are unvaccinated or partially vaccinated should complete the immunisation schedule.

These children should be investigated for immunological risk factors to seek a possible treatable condition predisposing them to infection. If they are found to fall into one of the risk groups in table 2, they should receive pneumococcal polysaccharide vaccine after the age of two years (and at least 2 months after the final dose of PCV).

All new cases of IPD in children eligible for routine or catch-up PCV will be followed up by the local NHS Board public health department in liaison with Health Protection Scotland. Those cases of IPD, who have been previously immunised with PCV, will be offered antibody testing against each of the 7 vaccine serotypes and advice on clinical and immunological investigation. A blood sample should be taken four weeks after infection to assess antibody response to disease and measure immunoglobulin levels. At this time, a booster dose of pneumococcal vaccine (irrespective of vaccination status of child) should be given. A second blood sample should be taken four weeks after vaccination to measure response to the booster dose.

⁴³ One month apart if necessary to ensure 2 doses are given before a dose at 13 months.

7. Vaccination of children with unknown or incomplete status

Where a child born in the UK presents with an inadequate or incomplete immunisation record, every effort should be made to clarify what vaccines they have had. A child who has not completed the routine programme for all vaccines should complete the course, including for pneumococcal vaccination. Children under 12 months of age require two doses of PCV, two months apart, followed by a dose at 13 months. Children aged between 12 and 24 months should be offered a single dose of PCV. Children aged over 24 months do not require vaccination.

Children coming to the UK may not have been offered pneumococcal vaccination previously. Where there is not reliable history of previous immunisation it should be assumed they are unimmunised and the UK recommendation should be followed.

8. Pneumococcal vaccination catch-up programme

Details of the pneumococcal catch-up programme for all children under two years of age are listed in Annexes 2 and 3.

9. Pharmacy issues

The following new vaccines will be offered as part of the routine programme. Full details on the products are available in the Summary of Product Characteristics (SPC).

Pneumococcal Conjugate Vaccine (PCV)

PCV, brand name Prevenar™ is manufactured by Wyeth Pharmaceuticals.

Presentation

Prevenar is presented as a suspension for injection in a pre-filled syringe supplied in a ten syringe pack without needles. The pack size (10 doses) is 144mm x 100mm x 63mm.

During storage a white deposit and clear supernatant can be seen. The vaccine should be shaken well to obtain a homogeneous white suspension and should not be used if it contains any particulate matter once shaken or shows any variation in appearance.

Dosage

A single dose of 0.5ml should be given at 2 months and 4 months followed by a third dose as a booster of 0.5ml at 13 months of age.

Administration

Vaccines are routinely given intramuscularly into the anterolateral thigh or the upper arm (infants over 1 year of age). This is to reduce the risk of localised reactions, which are more common when the vaccine is given subcutaneously. For individuals with a bleeding disorder, however, vaccines should be given by deep subcutaneous

injection to reduce the risk of bleeding. The vaccine can be given at the same time as other vaccines such as DTaP/IPV/Hib, MenC and MMR but in a different site.

It is recommended that infants under 1 year of age should be given vaccinations in the anterolateral aspect of the thigh. Where two injections are given in the same thigh, they should be separated by at least 2.5cm and a note be made of which vaccine is given in which site. This should be recorded in the Personal Child Health Record (PCHR – red book) and the child's GP record.

The vaccine must not be mixed with other concurrently administered vaccines.

Hib-MenC Vaccine

Hib-MenC, brand name Menitorix™ is manufactured by GlaxoSmithKline.

Presentation

Menitorix is presented as a one-dose pack containing a vial of white powder and a 0.5ml pre-filled syringe containing a clear colourless solvent. It is supplied with two separate needles - a green needle (21g x 38 mm) for reconstitution and a blue needle (23g x 25 mm) for administration. The pack size (one dose) is 55mm x 133mm x 35mm. Instructions for reconstitution of the vaccine are given at section 7 of the package leaflet.

Dosage

A single dose of 0.5ml is to be given as a booster at 12 months of age.

Administration

Vaccines are routinely given intramuscularly into the upper arm or anterolateral thigh. This is to reduce the risk of localised reactions, which are more common when the vaccine is given subcutaneously. For individuals with a bleeding disorder, however, vaccines should be given by deep subcutaneous injection to reduce the risk of bleeding.

Storage of vaccines

Vaccines should be stored in the original packaging at +2°C to +8°C and protected from light. All vaccines are sensitive to some extent to heat and cold. Heat speeds up the decline in potency of most vaccines, thus reducing their shelf life. Effectiveness cannot be guaranteed for vaccines unless they have been stored at the correct temperature. Freezing may cause increased reactogenicity and loss of potency for some vaccines. It can also cause hairline cracks in the container, leading to contamination of the contents.

10. Reporting of adverse reactions

Prevenar and Menitorix both carry a black triangle symbol (▼). This is a standard symbol added to the product information of a vaccine/medicine during the early

stages of marketing to encourage reporting of all suspected adverse reactions. If a doctor, nurse, pharmacist or parent suspects that any adverse reaction to one of these vaccines has occurred, they should report it to the Commission on Human Medicines (CHM) either the Yellow Card reporting form (e.g. in the BNF), the www.yellowcard.gov.uk website or by telephoning 0808 100 3352.

11. Vaccine supply

Vaccine Holding Centres will be advised of their indicative allocation based on GRO and SIRS data within the next three weeks. An initial six weeks allocation will be made to Vaccine Holding Centres five weeks prior to the commencement date to enable them to supply GP Practices and clinics with a four week supply in time for the start of the campaign. Orders for vaccine, against the indicative allocation should be made in the usual way. Requests for amounts over and above the allocated amounts should be made in advance to Margaret Johnston at NSS National Procurement at email Margaret.johnston2@nhs.net.

12. Vaccine Stock Management

Effective management of vaccines throughout the supply chain is an essential part of reducing wastage and maximising efficiency of the programme. Even small reductions in vaccine wastage can have a major impact on vaccine supplies and their financing.

Practices need to review their holdings of MenC vaccine in particular as the new routine programme only requires two doses of MenC vaccine to be given.

Prevenar packaging is significantly larger than other vaccine currently provided. Please ensure sufficient fridge space is available for the new vaccines. Details of the pack size are given on page 7 of this letter.

13. Consumables

Please note that needles will need to be ordered to administer Prevenar. The following product is recommended:

FTR163 blue needle 23g x 25 mm

This product may be ordered in the usual way. In order to manage the supplies of these consumables, please place regular orders to meet your needs rather than one very large order. Needles will not be supplied with the vaccine.

14. Vaccine call/recall

The SIRS system will be amended in line with the new vaccine schedule.

General practices should advise SIRS of any children who have already received conjugate pneumococcal vaccine prior to the introduction of routine vaccination, i.e. those at increased risk of pneumococcal infection.

15. Patient Group Directions

The requirement for Patient Group Directions (PGD) is described in HDL (2001)7, available from http://www.show.scot.nhs.uk/sehd/mels/HDL2001_07.htm.

For those practices that choose to use PGDs, specimen PGDs for Prevenar and Menitorix are being developed and will be available at <http://www.show.scot.nhs.uk/sehd>. NHS Boards may choose to use these drafts as the basis of their PGDs and tailor them to reflect local needs.

16. Funding and Service Arrangements

NHS Employers has reached agreement with the BMA General Practitioners Committee.

GPs will be remunerated £15.02 per child for the delivery of the pneumococcal vaccinations and the additional vaccination visit at 12 months to deliver the combined Hib and Men C vaccine. The Statement of Financial Entitlement will be amended and back dated to 4 September 2006.

The vaccines will be made available and distributed to the NHS through the Vaccine Holding Centres. The cost of the vaccine and administrative costs are expected to be met by NHS Boards.

17. Consent

The changes to the vaccine programme will not affect the consent process: consent must be obtained before administration of all vaccines and is not brand specific.

Consent obtained before the occasion on which a child is brought for immunisation is only an agreement for the child to be included in the national childhood immunisation programme. It does not mean that consent is in place for each future immunisation. There is no legal requirement for consent to be in writing.

Health professionals involved in immunisation must ensure that:

- parents/carers have access to the new information;
- that there is sufficient opportunity for them to discuss any issues arising; and
- that they are properly informed of the benefits of the new vaccines, the possible side effects and how to treat them.

18. Information for parents and healthcare professionals

To support the new changes to the childhood immunisation schedule NHS Health Scotland has produced a range of information resources. New leaflets, and factsheets for parents and healthcare professionals will be sent directly to GP practices, community pharmacists, health promotion units and NHS 24 call centres in August. These resources should be shared with all colleagues involved in giving or advising about immunisation, including health visitors, and practice nurses.

Further copies of these resources can be ordered from NHS Board Health Promotion Departments. In case of difficulty contact marketing@health.scot.nhs.uk .

Resources will also be available to view and download from the www.healthscotland.com/immunisation website in August. The website will be updated to reflect the changes to the programme, and a new section for Hib/MenC immunisation is being created.

TABLE 2 Pneumococcal Clinical Risk Groups for Children

Note: All children, including those in clinical risk groups, should be offered PCV according to the new routine immunisation schedule. Children in the clinical risk groups listed below, aged 2 months to under 5 years of age should receive 7-valent pneumococcal conjugate vaccine (PCV), according to Annex 1, paragraph 5. This should be followed by a single dose of 23-valent pneumococcal polysaccharide vaccine when they are 2 years of age or over (and at least two months after the last dose of PCV). Children over 5 years of age should receive a single dose of pneumococcal polysaccharide vaccine.

Clinical risk group	Examples (decision based on clinical judgement)
Asplenia or dysfunction of the spleen	This includes conditions such as homozygous sickle cell disease and coeliac syndrome that may lead to splenic dysfunction.
Chronic respiratory disease	This includes chronic obstructive pulmonary disease (COPD), including chronic bronchitis and emphysema; and such conditions as bronchiectasis, cystic fibrosis, interstitial lung fibrosis, pneumoconiosis and bronchopulmonary dysplasia (BPD). Children with respiratory conditions caused by aspiration, or a neuromuscular disease (e.g. cerebral palsy) with a risk of aspiration. Asthma is not an indication, unless continuous or frequently repeated use of systemic steroids (as defined in Immunosuppression below) is needed.
Chronic heart disease	This includes those requiring regular medication and/or follow-up for ischaemic heart disease, congenital heart disease, hypertension with cardiac complications, and chronic heart failure.
Chronic renal disease	This includes nephrotic syndrome, chronic renal failure, renal transplantation.
Chronic liver disease	This includes cirrhosis, biliary atresia, chronic hepatitis
Diabetes (requiring insulin or oral hypoglycaemic drugs)	This includes type 1 diabetes requiring insulin or type 2 diabetes requiring oral hypoglycaemic drugs. It does not include diabetes that is diet controlled.
Immunosuppression	Due to disease or treatment, including asplenia or splenic dysfunction and HIV infection at all stages. Patients undergoing chemotherapy leading to immunosuppression. Individuals treated with or likely to be treated with systemic steroids for more than a month at a dose equivalent to prednisolone 20mg or more per day (any age), or for children under 20kg, a dose of $\geq 1\text{mg/kg/day}$. <i>Some immunocompromised patients may have a suboptimal immunological response to the vaccine.</i>
Individuals with cochlear implants	<i>It is important that immunisation does not delay the cochlear implantation.</i> Where possible, pneumococcal vaccination should be completed at least 2 weeks prior to surgery to allow a protective immune response to develop. In some cases it will not be possible to complete the course prior to surgery. In this instance, the course should be started at any time prior to or following surgery and completed according to the immunisation schedule.
Individuals with cerebrospinal fluid leaks	This includes leakage of cerebrospinal fluid such as following trauma or major skull surgery.

Pneumococcal Vaccination Catch-Up Programme

1. Timing of Pneumococcal Catch-Up Campaign

The pneumococcal catch-up campaign will start on 4 September 2006. Our aim is to ensure that the target cohorts are offered vaccination appropriate for their age within 6 months of the start of the programme.

2. The Cohort

Children who will be over 2 months of age and under 2 years of age at the time of introduction will need to be invited to receive pneumococcal vaccine.

Children aged 2 months or under at the time of introduction will be offered pneumococcal vaccine as part of the new routine immunisation programme (see Annex 1). Children over 2 years of age will not be part of the catch-up programme. The risk for children over 2 years of age becoming ill with pneumococcal infection is considerably less than in younger age groups. It is likely that pneumococcal infections in all age groups will fall as a result of introduction of the programme in the under two's.

3. The immunisations to be offered

The recommended schedule for implementing the programme is summarised in Annex 3. The child's date of birth runs down the left-hand side of the table, and the month in which the vaccine is recommended to be given runs along the top of the table.

In summary:

Children born between 5 September 2004 and 3 August 2005 (i.e. aged over 13 months of age and under 2 years at the start of the programme) should be offered one dose of PCV.

Children born between 4 August 2005 and 3 February 2006 (i.e. aged 8 months to 13 months of age at the start of the programme) should be offered one dose of PCV at their routine 13 month visit.

Children born between 4 February 2006 and 3 July 2006 (i.e. aged over two months and under 8 months of age at the start of the programme) should be offered two doses of PCV separated by a period of two months. These children should also be offered a further dose at 13 months of age.

The following scenarios help to illustrate the use of the table:

- a) A baby born on 21 June 2006 should be offered PCV at the routine 4 month visit in October, a second dose at an additional 6 month visit in December, and then a booster dose at the scheduled 13 month visit.

- b) A child born 6 November 2005 should be offered PCV at the scheduled 13 month visit in December.
- c) A child born on 2 April 2005 should be offered one dose of PCV in November.
- d) A child born on 4 September 2004 is not eligible for the vaccine as they are over two years of age when the programme starts. Pneumococcal infections occur less frequently in children aged 2 years and over, and it is likely that pneumococcal infections in all age groups will fall as a result of introduction of the programme in the under two's.
- e) A baby born on 17 July 2006 will not be part of the catch-up programme. This baby will receive pneumococcal vaccination as part of the routine programme.

4. Reporting of adverse reactions

See page 8.

5. Vaccine supply

Vaccine Holding Centres will be advised of their indicative allocation based on GRO and SIRS data within the next three weeks. An initial six weeks allocation will be made to Vaccine Holding Centres five weeks prior to the commencement date to enable them to supply GP Practices and clinics with a four week supply in time for the start of the campaign. Orders for vaccine, against the indicative allocation should be made in the usual way. Requests for amounts over and above the allocated amounts should be made in advance to Margaret Johnston at NSS National Procurement at email Margaret.johnston2@nhs.net

6. Vaccine stock management

Managing supplies of vaccine during the pneumococcal catch-up programme presents challenges in vaccine management with which health professionals are familiar. All staff ordering vaccines need to ensure that vaccine wastage is reduced as far as possible by ensuring fridge space is available before ordering and storing the vaccine correctly. Practices who find that they have excess pneumococcal vaccine remaining at the end of the catch-up programme should use it in the routine programme. Vaccine wastage for this catch-up programme should be negligible.

7. Consumables

Please note that needles will need to be ordered to administer Prevenar.

FTR163 blue needle 23g x 25 mm

In order to manage the supplies of these consumables, please place regular orders to meet your needs rather than one very large order. Needles and syringes will not be supplied with the vaccine.

8. Vaccine call/recall

The SIRS system will be amended in line with the new vaccine schedule.

General practices should advise SIRS of any children who have already received conjugate pneumococcal vaccine outwith the previous routine schedule, i.e. those at increased risk of pneumococcal infection.

General practices will need to provide sufficient additional vaccine appointments or catch-up clinics.

A draft letter is attached at Annex 4 for practices that send out their own appointments.

9. Patient Group Directions

The requirement for Patient Group Directions (PGD) is described in HDL (2001)7, available from http://www.show.scot.nhs.uk/sehd/mels/HDL2001_07.htm.

For those practices that choose to use PGDs, specimen PGDs for Prevenar and Menitorix are being developed and will be available at <http://www.show.scot.nhs.uk/sehd>. NHS Boards may choose to use these drafts as the basis of their PGDs and tailor them to reflect local needs.

10. Funding and service arrangements

NHS Employers has reached agreement with the BMA General Practitioners Committee.

GPs will be remunerated £7.51 as an item of service payment for each child vaccinated. The Statement of Financial Entitlement will be amended and back dated to 4 September 2006.

The vaccines will be made available and distributed to the NHS through the Vaccine Holding Centres. The cost of the vaccine and administrative costs are expected to be met by NHS Boards.

11. Consent

The introduction of the pneumococcal catch-up programme will not affect the consent process: consent must be obtained before administration of all vaccines and is not vaccine-product specific.

Consent obtained before the occasion on which a child is brought for immunisation is only an agreement for the child to be included in the national childhood immunisation programme. It does not mean that consent is in place for each future immunisation. There is no legal requirement for consent to be in writing.

Health professionals involved in immunisation must ensure that:

- parents/carers have access to the new information;
- that there is sufficient opportunity for them to discuss any issues arising, and
- that they are properly informed of the benefits of the new vaccines, the possible side effects, and how to treat them.

12. Information for parents and healthcare professionals

To support the new changes to the childhood immunisation schedule NHS Health Scotland has produced a range of information resources. New leaflets, and factsheets for parents and healthcare professionals will be sent directly to GP practices, community pharmacists, health promotion units and NHS 24 call centres in August. These resources should be shared with all colleagues involved in giving or advising about immunisation, including health visitors, and practice nurses.

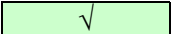
Further copies of these resources can be ordered from NHS Board Health Promotion Departments. In case of difficulty contact marketing@health.scot.nhs.uk.

Resources will also be available to view and download from the www.healthscotland.com/immunisation website in August. The website will be updated to reflect the changes to the programme, and a new section for Hib/MenC immunisation is being created.

Pneumococcal Vaccination Catch-Up Table

Recommended schedule for catch-up vaccination from 4 September 2006							
	4 Sept to 3 Oct	4 Oct to 3 Nov	4 Nov to 3 Dec	4 Dec to 3 Jan	4 Jan to 3 Feb	4 Feb to 3 Mar	
Child's date of birth							Child's age at vaccination (months)
5/9/04 to 3/11/04	√						23
4/11/04 to 3/12/04	√						22
4/12/04 to 3/1/05		√					22
4/1/05 to 3/2/05		√					21
4/2/05 to 3/3/05			√				21
4/3/05 to 3/4/05			√				20
4/4/05 to 3/5/05				√			20
4/5/05 to 3/6/05				√			19
4/6/05 to 3/7/05					√		19
4/7/05 to 3/8/05					√		18
4/8/05 to 3/9/05	√						13
4/9/05 to 3/10/05		√					13
4/10/05 to 3/11/05			√				13
4/11/05 to 3/12/05				√			13
4/12/05 to 3/1/06					√		13
4/1/06 to 3/2/06						√	13
4/2/06 to 3/3/06*		√		√			8, 10
4/3/06 to 3/4/06*		√		√			7, 9
4/4/06 to 3/5/06*	√		√				5, 7
4/5/06 to 3/6/06*	√		√				4, 6
4/6/06 to 3/7/06*		√		√			4, 6

Notes

 Indicates the month in which the child should be offered PCV

*Children in this age group will receive a booster dose of PCV at 13 months of age and a dose of Hib/MenC at 12 months of age.

Please note that there are sufficient supplies of PCV vaccine for all children born between 5/9/04 and 3/8/05 to be offered PCV as soon as it is practically possible after the start of the programme. This will provide general practices with the flexibility to immunise eligible children over a shorter time period.

Suggested template letter of appointment for those practices sending out their own invitations for the pneumococcal catch-up programme

PRACTICE NAME

ADDRESS

[Date]

[Recipient's Address]

Dear Parent

The Scottish Government Health Directorate has recommended that your child needs a catch-up dose of pneumococcal conjugate vaccine (PCV). This vaccine has recently been introduced to the routine childhood immunisation programme and includes a catch-up for all children under two years of age. We are writing to invite you to bring your child for this vaccination on:

[date and time]

[venue]

This vaccination is important for your child because of the risks of pneumococcal disease, which include meningitis and septicaemia (blood poisoning) in children under two years of age. For more information about this vaccination, please read the leaflet (enclosed). If you have any further questions, please get in touch with your health visitor, practice nurse or GP.

As a practice we recommend pneumococcal conjugate vaccine for your child and hope that you will be able to bring your child for this appointment. If the above time and date is not suitable for you, please contact the practice to arrange another appointment.

Yours sincerely

[Click here and type your name]

ANNEX J

VACCINATIONS AND IMMUNISATIONS TO BE PROVIDED UNDER ADDITIONAL SERVICES

Persons Not Travelling Abroad

Disease	Groups of persons affected
1. Diphtheria Tetanus Either separately or combined	a. Children aged 6 and over who have not had the basic course of immunisation
	b. Staff in hospital considered to be at risk of infection of diphtheria (see Note 1)
	c. Children aged 6 and over who have had the basic course of immunisation but not a reinforcing dose.
2. Tetanus	a. If not previously immunised - children at 15-19 years of age or on leaving school; persons after leaving school.
	b. If previously immunised - persons on leaving school or entering higher education or starting work; thereafter, persons who have not had a reinforcing dose in <ul style="list-style-type: none"> i. the previous 5 years, and then ii. the previous 5-15 years
3. Poliomyelitis	a. Persons aged 6 years and under age 40 and parents/guardians of children being given oral polio vaccine. Groups at special risk (see Note 2). (Basic course).
	b. If previously immunised but without receiving a reinforcing dose - persons aged 6 and over at school or on leaving school or entering higher education or starting work. Groups at special risk (see Note 2.)
4. Smallpox (see Notes 3 and 4)	Groups at special risk (see Note 3).
5. Measles, Mumps, Rubella (MMR combined vaccine) Single Rubella	Children from age 6 to 15 years who have not been previously immunised with MMR combined vaccine. Women of child-bearing age who are not pregnant and are sero-negative; and male staff working in ante-natal clinics who are sero-negative.
5a. Measles, Mumps, Rubella second dose	i. Children given the pre-school MMR second dose at the same time as the Diphtheria, Tetanus and Polio pre-school immunisation (within the normal time frame for pre-school boosters). ii. Children given the pre-school MMR second dose separately from one or more of the other pre-school boosters,



INVESTOR IN PEOPLE



	<p>that is Diphtheria, Tetanus and Polio, within the normal time frame for the pre-school boosters. (This is required only in cases where, in the judgement of the health professional giving the immunisations, it has not been possible to give all the pre-school boosters at the arranged initial appointment).</p> <p>iii. Children born after 1 January 1990 who are too old to be called for pre-school boosters after 1 October 1996, but are too young to have been in the 1994/95 MR campaign.</p>
6. Measles(single Antigen vaccine) (see Note 7)	Children from age 6 to 15 years who have not been immunised against measles and who have not had measles.
7. Rubella	Girls between their 10th and 14th birthdays who have not previously been immunised with MMR combined vaccine. Women of child-bearing age who are not pregnant and are sero-negative; and male staff working in ante-natal clinics who are sero-negative.
8. Anthrax	Groups at special risk (see Note 5).
9. Typhoid and Paratyphoid Either vaccine or typhoid combined	Staff in hospitals considered to be at risk of infection (see Note 1).
10. Rabies	Groups at special risk (see Note 6).
11. Infectious hepatitis	Persons in institutions who are exposed to a high risk of infection and for whom vaccination is recommended by the Community Medicine Specialist in Communicable Diseases.
11a. Haemophilus Influenzae b (Hib)	Children aged from 6 months to 3 years and 364 days on 1 April 2003, and all children who reach the age of 6 months between 1 April 2003 until 2 October 2003. (See Notes 8).
12. Vaccination in pursuance of public health policy (as in items 1-4 and 8-11) given as part of an emergency programme under the direction of the appropriate Board during a local outbreak of disease where the person vaccinated is a member of a group for which vaccination is recommended by the Community Medicine Specialist in Communicable Diseases, including a close contact of a person diagnosed by the general practitioner for whom vaccination is subsequently approved by the Community Medicine Specialist in Communicable Diseases.	
Disease	Groups of persons affected
12a. Group C Meningococcal	i. Children aged under 5 months will receive 3 doses (conjugate meningococcal C vaccine)
	ii. Children aged 5 months and to 11 months will receive 2 doses (conjugate meningococcal C vaccine)
	iii. Persons aged 12 months and up to and including age 24 years not previously immunised with conjugate meningococcal C vaccine will receive one dose (conjugate meningococcal C vaccine)

12b. These payments reimburse GPs for immunising only those children and young people prioritised in the meningococcal C immunisation programme from Autumn 1999.	
Disease	Groups of persons affected
12c. Pneumococcal Disease	Adults who are, or will reach, age 65 and over by 31 March 2004. Thereafter patients will be eligible on reaching 65.
Persons Travelling Abroad 13. The following types of vaccinations are to be given to groups of persons leaving the United Kingdom for travel abroad, as defined below. Vaccination requirements of countries may vary and it is for the intending traveller to obtain authoritative information of the vaccination requirements of the country to be visited from the embassy/mission of that country.	
Disease	Groups of persons affected
14. Smallpox (see Note 4)	a. All persons travelling to Africa, Asia and America (including Canada and USA only when vaccination is a requirement of entry to those countries).
	b. All persons travelling to an infected area. c. All persons travelling to a country which requires visitors to have an International Certificate of Vaccination against Smallpox.
15. Typhoid and Paratyphoid Either typhoid vaccine or combined	a. All persons travelling outside the UK except to Canada, USA, Australia, New Zealand and northern Europe. ("Northern Europe" includes Belgium, Denmark, Iceland, the Netherlands, Norway and Sweden). b. All persons travelling to an infected area. c. All persons travelling to countries where it is a condition of entry that visitors should have been immunised.
16. Cholera	a. All persons travelling to Africa and Asia. b. All persons travelling to an infected area. c. All persons travelling to countries where it is a condition of entry that visitors should have been immunised.
17. Poliomyelitis	a. All persons travelling to countries outside Europe except Canada, USA, Australia, and New Zealand (Europe includes Cyprus and Turkey). b. All persons travelling to an infected area. c. All persons travelling to countries where it is a condition of entry that visitors should have been immunised.
18. Infectious hepatitis	Persons (particularly those) going to reside for 3 months or



	longer or who, if infected, might be less resistant because of pre-existing disease travelling outside Northern Europe, Australia or New Zealand to areas eg of poor sanitation, where the degree of exposure to infections is likely to be high.
Note 1 Groups at special risk are hospital doctors and nurses and other staff likely to come into contact with cases of diphtheria, typhoid and paratyphoid, as the case may be, and laboratory staff likely to handle material contaminated with the organisms of these diseases.	
Note 2 Groups at special risk and eligible for vaccination against poliomyelitis regardless of age are: General practitioners. General practitioners' practice staff in contact with patients. Ambulance staff. Medical students. Practising dental surgeons and others in contact with dental patients. Practising nurses in hospitals and elsewhere. Other hospital staff in contact with patients. Public health staff who may come into contact with poliomyelitis cases. The families of the above groups. Laboratory staff likely to handle material contaminated with poliomyelitis virus.	
Note 3 Groups at special risk and eligible for vaccination and regular re-vaccination against smallpox regardless of age are: i. Regular re-vaccination at not less than yearly intervals: Doctors, nurses and others liable to serve on the staff of smallpox hospitals, any persons likely to have to deal at short notice with smallpox cases and laboratory staff likely to handle material contaminated with smallpox virus. ii. Regular re-vaccination at not less than 3-yearly intervals: Other health services staff who come into contact with patients.	
Note 4 A vaccination or re-vaccination against smallpox is considered to be successful if a "major reaction" (as defined in paragraph 27 of the Memorandum on Vaccination against Smallpox, 1974) has occurred.	
Note 5 The workers exposed to special risks of contracting anthrax are mainly those working in establishments such as tanneries, glue, gelatine, soap and bonemeal factories and woollen mills and regularly handling any of the raw materials shown below: Goat hair, including mohair and cashmere (unless previously disinfected by an approved factory in Great Britain). East Indian wool, ie wool exported from India, Pakistan and Bangladesh.	

<p>Persian wool, ie wool exported from Persian Gulf ports, including wool from Iran, Iraq, Saudi-Arabia, Kuwait, etc.</p> <p>Egyptian wool.</p> <p>Chinese and Mongolian wool, ie wool exported from the People's Republic of China and the Mongolian People's Republic.</p> <p>Alpaca.</p> <p>Camel hair.</p> <p>Tail or mane horsehair (raw or dressed) from the People's Republic of China, Taiwan, the Mongolian People's Republic or the Union of Soviet Socialist Republics.</p> <p>Dry and dry-salted hides and skins imported from Africa, Asia and Central and South America.</p> <p>Trimnings from dry and dry-salted raw hides, imported from Africa, Asia, and Central and South America.</p> <p>Bones and bonemeal, hoof and horn meal imported from India, Pakistan and Bangladesh.</p>

<p>Note 6</p> <p>Groups at special risk and eligible for vaccination against rabies regardless of age are:</p> <ol style="list-style-type: none"> at kennels and catteries approved by the Ministry of Agriculture, Fisheries and Food for the quarantine of imported dogs, cats, etc; at quarantine premises in zoological establishments; by carrying agents authorised to carry imported dogs, cats, etc; at approved research and acclimatisation centres where primates and other imported mammals are housed; in laboratories handling rabies virus; at seaports and airports where they are likely to come into contact with imported animals or animals on ships or aircraft, eg Customs and Excise and police officers; as veterinary and technical staff of MAFF; as inspectors appointed by local authorities under the Diseases of Animal Act or employed otherwise who, by reason of their employment, encounter enhanced risk; those who regularly handle bats, including on a voluntary basis <p>and, where an area is declared to be rabies-infected by the Department of Agriculture, Fisheries and Food,</p> <ol style="list-style-type: none"> Persons directly involved in control measures carried out under the direction of the Community Medicine Specialist in Communicable Diseases, together with veterinary surgeons engaged in private practice within the infected area and their ancillary staff. <p>Vaccine is issued, free of charge, by certain laboratories of the Public Health Service at the request of the doctor undertaking the vaccination. The Community Medicine Specialist in Communicable Diseases can advise the practitioner on the recommended schedule of vaccination and the detailed arrangements for the supply of the vaccine.</p> <p>Note 7</p>
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MMR combined vaccine should be given in preference to single-antigen measles vaccine and regardless of a history of mumps, measles or rubella infection.

Note 8

The haemophilus influenzae b (Hib) vaccine should be given in accordance with the aims of the catch-up campaign notified in the CMO letter dated 24 April 2003 (*SEHD/CMO(2003)6*) including supporting guidance, and with Chapter 8 of 'Immunisation against Infectious Disease', 1996 edition.