QOF Action Plan

Target: To achieve XXX points

QOF Leads:

	Lead responsibilities
GP 1	
GP2	
GP 3	
GP 4	
Nurse Practitioner	
Practice Nurse	
Practice Manager	

General commitments to help achieve QOF:

- To undertake a clinical meeting each week. These will include discussion of clinical audits, progress against clinical targets, and clinical system flags and alerts. Reminders in bullet points for actions needed in relevant disease areas clearly displayed in all consulting rooms
- Monthly QOF meeting including the Practice Manager, QOF manager, relevant admin staff and all clinicians
- Weekly meetings between GP 1 and QOF Manager to audit progress using clinical system

Example priorities within the first 6 months:

- Provide opportunity for the QOF Manager to visit high performing QOF Practices to share good practice
- Review the appointments system to improve access (especially advance booking)
- Update disease registers
- Completing note summarisation to 100% (currently XXX%)
- Review clinical templates to help make them easier to use for clinicians. Communicate importance of consistent use of templates by all clinicians including locums
- Review patient recall systems with QOF Manager with a view to improving efficiency and response rates
- Full utilisation of alert/dairies to flag up in each consultation what actions are required to achieve QOF indicators (i.e. update smoking status, take BP)

Clinical Indicators

Changes from 2011/12 indicator	2011/12 achievement	2012/13 indicators	points	Payment stages	Current achievement 2012/13	Action (SMART)
CHD						
Comments on prevalence and exception reporting:						
		Records				
		CHD 1. The practice can produce a register of patients with coronary heart disease	4			
		Diagnosis and initial management				
CHD 13. The percentage of patients with newly diagnosed angina (diagnosed after 1 April 2011) who are referred for specialist assessment		Retired	7	40-90%		
		Ongoing management				
Upper threshold has increased from 71% to 75%		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	40-75%		Ensure achievement of new threshold
		CHD 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	17	40-70%		
Re-worded to omit *"(unless a contraindication or side-effects are recorded)"*		CHD9. The percentage of patients with coronary heart disease with a record in the preceding 15 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken	7	40-90%		

Re-worded to omit *"(unless a contraindication or side-effects are recorded)"* Upper threshold has increased from 60% to 65%		CHD 10. The percentage of patients with coronary heart disease who are currently treated with a beta-blocker	7	40-65%		Ensure achievement of new threshold
2011/12 wording: CHD 14. The percentage of patients with a history of myocardial infarction (from 1 April 2011) currently treated with an ACE inhibitor (or ARB if ACE intolerant), aspirin or an alternative anti-platelet therapy, beta-blocker and statin (unless a contraindication or side effects are recorded)		CHD 14. The percentage of patients with a history of myocardial infarction (from 1 April 2011) currently treated with an ACE inhibitor (or ARB if ACE intolerant), aspirin or an alternative anti-platelet therapy, beta-blocker and statin *NICE 2010 menu ID: NM07*	10	40-80%		
Lower threshold has increased from 40% to 50%		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	50-90%		Ensure achievement of new threshold
CVD						
Comments on prevalence and exception reporting:						
		Initial diagnosis				
Upper threshold has increased from 70% to 75%		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 (aged 30 to 74 years) who have had a face to face cardiovascular risk assessment at the	8	40-75%		Ensure achievement of new threshold

		outset of diagnosis (within three months of the initial diagnosis) using an agreed risk assessment tool.				
		Ongoing management				
Upper threshold has increased from 70% to 75%		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	40-75%		Ensure achievement of new threshold
Heart Failure						
Comments on prevalence and exception reporting:						
		Records				
		HF 1. The practice can produce a register of patients with heart failure	4			
		Initial diagnosis				
Lower threshold has increased from 40% to 50%		HF 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	6	50-90%		Ensure achievement of new threshold
		Ongoing management				
Lower threshold has increased from 40% to 45%		HF 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 contra-indication	10	45-80%		Ensure achievement of new threshold
Upper threshold has increased from 60% to 65%		HF 4. The percentage of patients with a current diagnosis of heart failure due to LVD who are currently treated with	9	40-65%		Ensure achievement of new threshold

		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.				
Stroke and Transient Ischaemic Attack (TIA)						
Comments on prevalence and exception reporting:						
		Records				
		STROKE 1. The practice can produce a register of patients with stroke or TIA	2			
Lower threshold has increased from 40% to 45%		STROKE 13. The percentage of new patients with a stroke or TIA who have been referred for further investigation	2	45-80%		Ensure achievement of new threshold
		Ongoing management				
Upper threshold has increased from 71% to 75%		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	40-75%		Ensure achievement of new threshold
Lower threshold has increased from 40% to 50%		STROKE 7. The percentage of patients with TIA or stroke who have a record of total cholesterol in the last 15 months	2	50-90%		Ensure achievement of new threshold
Upper threshold has increased from 60% to 65%		STROKE 8. The percentage of patients with TIA or stroke whose last measured total cholesterol (measured in the previous 15 months) is 5mmol/l or less	5	40-65%		Ensure achievement of new threshold
Re-worded to omit *"(unless a contraindication or side-effects are recorded)"* Lower threshold has increased from 40% to 50%		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	4	50-90%		Ensure achievement of new threshold

		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						
Comments on prevalence and exception reporting:						
		Records				
		BP 1. The practice can produce a register of patients with established hypertension	6			
		Ongoing management				
Reduced by 8 points to 8 points in 2012/13 Lower threshold has increased from 40% to 50%		BP 4. The percentage of patients with hypertension in whom there is a record of the blood pressure in the previous 9 months	8	50-90%		Ensure achievement of new threshold
Reduced by 2 points to 55 points in 2012/13 Lower threshold has increased from 40% to 45% and upper threshold has increased from 70% to 80%		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	55	45-80%		Ensure achievement of new threshold
Diabetes mellitus						
Comments on prevalence and exception reporting:						
		Records				
DM 19.The practice can produce a register of all patients aged 17 years and over with diabetes		Retired				

mellitus, which specifies whether the patient has Type 1 or Type 2 diabetes						
		DM32. The practice can produce a register of all patients aged 17 years and over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed *NICE 2011 menu ID: NM41*	6			New indicator. Similar to previous DM 19. Check register to ensure compliance with new wording for register criteria
		Ongoing management				
Reduced by 2 points to 1 point in 2012/13 Lower threshold has increased from 40% to 50%		DM 2.The percentage of patients with diabetes whose notes record BMI in the previous 15 months	1	50-90%		Ensure achievement of new threshold
Re-worded from "*The percentage of patients with diabetes in whom the last IFCC-HbA1c is 59mmol/mol (equivalent to HbA1c of 7.5% in DCCT values) or less (or equivalent test/reference range depending on local laboratory) in the preceding 15 months"*		DM 26. The percentage of patients with diabetes in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 15 months *NICE 2010 menu ID: NM14*	17	40-50%		
Re-worded from *"The percentage of patients with diabetes in whom the last IFCC-HbA1c is 64mmol/mol (equivalent to HbA1c of 8% in DCCT values) or less (or equivalent test/reference range depending on local laboratory) in the preceding 15 months"* Lower threshold has increased from 40% to 45%		DM 27. The percentage of patients with diabetes in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 15 months	8	45-70%		Ensure achievement of new threshold
2011/12 wording: DM 28. The percentage of patients with diabetes in whom the last		DM 28. The percentage of patients with diabetes in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding	10	50-90%		Ensure achievement of new threshold

IFCC-HbA1c is 75 mmol/mol (equivalent to HbA1c of 9 in DCCT values) or less (or equivalent test/reference range depending on local laboratory) in the preceding 15 months Lower threshold has increased from 40% to 50%		15 months				
Lower threshold has increased from 40% to 50%		DM 21. The percentage of patients with diabetes who have a record of retinal screening in the previous 15 months	5	50-90%		Ensure achievement of new threshold
Lower threshold has increased from 40% to 50%		DM 29. The percentage of patients with diabetes with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes or previous ulcer) or 4 ulcerated foot within the preceding 15 months. *NICE menu ID: NM13*	4	50-90%		Ensure achievement of new threshold
Lower threshold has increased from 40% to 50%		DM 10. The percentage of patients with diabetes with a record of neuropathy testing in the previous 15 months	3	50-90%		Ensure achievement of new threshold
Lower threshold has increased from 40% to 45%		DM 30. The percentage of patients with diabetes in whom the last blood pressure is 150/90 or less *NICE 2010 menu ID: NM01*	8	45-71%		Ensure achievement of new threshold
Upper threshold has increased from 60% to 65%		DM 31. The percentage of patient with diabetes in whom the last blood pressure is 140/80 or less *NICE 2010 menu ID: NM02*	10	40-65%		Ensure achievement of new threshold

Lower threshold has increased from 40% to 50%		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	50-90%		Ensure achievement of new threshold
Reduced by 2 points to 1 point in 2012/13 Lower threshold has increased from 40% to 50%		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	1	50-90%		Ensure achievement of new threshold
Lower threshold has increased from 40% to 45%		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	45-80%		Ensure achievement of new threshold
Upper threshold has increased from 70% to 75%		DM 17. The percentage of patients with diabetes whose last measured total cholesterol within the previous 15 months is 5mmol/l or less	6	40-75%		Ensure achievement of new threshold
Lower threshold has increased from 40% to 45%		DM 18. The percentage of patients with diabetes who have had influenza immunisation in the preceding 1 September to 31 March	3	45-85%		Ensure achievement of new threshold
Chronic obstructive pulmonary disease (COPD)						
Comments on prevalence and exception reporting:						
		Records				
		COPD 14. The practice can produce a register of patients with COPD	3			
		Initial diagnosis				
Lower threshold has increased from 40% to 45%		COPD 15. The percentage of all patients with COPD diagnosed after 1 April 2011 in whom the diagnosis has been confirmed by post bronchodilator	5	45-80%		Ensure achievement of new threshold

		spirometry				
		Ongoing management				
Upper threshold has increased from 70% to 75%		COPD 10. The percentage of patients with COPD with a record of FeV1 in the previous 15 months	7	40-75%		Ensure achievement of new threshold
		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						
Comments on prevalence and exception reporting:						
		Records				
		EPILEPSY 5. The practice can produce a register of patients aged 18 and over receiving drug treatment for epilepsy	1			
		Ongoing management				
Lower threshold has increased from 40% to 50% Guidance has been changed to include telephone reviews in 2012/13		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	50-90%		Ensure achievement of new threshold Ensure telephone reviews are being appropriately recorded by all clinicians
Lower threshold has increased from 40% to 45%		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	6	45-70%		Ensure achievement of new threshold

		recorded in the previous 15 months				
Lower threshold has increased from 40% to 50%		EPILEPSY 9. The percentage of women under the age of 55 years who are taking antiepileptic drugs who have a record of information and counselling about contraception, conception and pregnancy in the preceding 15 months *NICE 2010 menu ID: NM03*	3	50-90%		Ensure achievement of new threshold
Hypothyroid						
Comments on prevalence and exception reporting:						
		Records				
		THYROID 1. The practice can produce a register of patients with hypothyroidism	1			
		Ongoing management				
Lower threshold has increased from 40% to 50%		THYROID 2. The percentage of patients with hypothyroidism with thyroid function tests recorded in the previous 15 months	6	50-90%		Ensure achievement of new threshold
Cancer						
Comments on prevalence and exception reporting:						
		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				

Lower threshold has increased from 40% to 50%		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	50-90%		Ensure achievement of new threshold
Palliative care						
Comments on prevalence and exception reporting:						
		Records				
		PC 3. The practice has a complete register available of all patients in need of palliative care/support irrespective of age	3			
		Ongoing management				
		PC 2. The practice has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed	3			
Mental health						
Comments on prevalence and exception reporting:						
		Records				
		MH 8. The practice can produce a register of people with schizophrenia, bipolar disorder and other psychoses	4			
		Ongoing management				
Lower threshold has increased from 40% to 50%		MH11. The percentage of patients with schizophrenia, bipolar affective disorder and other pyschoses who have a record of alcohol consumption	4	50-90%		Ensure achievement of new threshold

		in the preceding 15 months *NICE 2010 menu ID: NM15*				
Lower threshold has increased from 40% to 50%		MH12. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 15 months *NICE 2010 menu ID: NM16*	4	50-90%		Ensure achievement of new threshold
Lower threshold has increased from 40% to 50%		MH13The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 15 months *NICE 2010 menu ID: NM17*	4	50-90%		Ensure achievement of new threshold
MH14		MH14. Re numbered as MH19				
MH14 has been re-numbered as MH19 following a change to the business rules to include an exclusion cluster for patients already diagnosed with CVD. Lower threshold has increased from 40% to 45%		MH19. The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol:hdl ratio in the preceding 15 months *NICE 2010 menu ID: NM18*	5	45-80%		Ensure achievement of new threshold Review and include the exclusion cluster for patients already diagnosed with CVD
MH15		MH15 renumbered as MH20 to include HbA1c				
Lower threshold increased from 40% for MH15 in 2011/12 to 45% for MH20 in 2012/13		MH20. The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding15 months *NICE 2011 menu ID: NM42*	5	45–80%		New indicator – Similar to MH15 but with inclusion of HbA1c. Check all patients with HbA1c are counted correctly Ensure achievement of new threshold

Lower threshold has increased from 40% to 45%		MH16. The percentage of patients (aged from 25 to 64 in England and Northern Ireland, from 20 to 60 in Scotland and from 20 to 64 in Wales) with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years *NICE 2010 menu ID: NM20*	5	45-80%		Ensure achievement of new threshold
Lower threshold has increased from 40% to 50%		MH17. The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months *NICE 2010 menu ID: NM21*	1	50-90%		Ensure achievement of new threshold
Lower threshold has increased from 40% to 50%		MH 18. The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the previous 4 months *NICE 2010 menu ID: NM22*	2	50-90%		Ensure achievement of new threshold
Lower threshold has increased from 25% to 30% and upper threshold increased from 50% to 55%		MH 10. The percentage of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate	6	30-55%		Ensure achievement of new threshold
Asthma						
Comments on prevalence and exception reporting:						
		Records				
		ASTHMA 1. The practice can produce	4			

		a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the previous twelve months				
		Initial management				
Lower threshold has increased from 40% to 45%		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	45-80%		Ensure achievement of new threshold
		Ongoing management				
ASTHMA 3.		ASTHMA 3. Re-numbered as ASTHMA 10				
Lower threshold has increased from 40% in Asthma 3 to 45% for Asthma 10		ASTHMA 10. The percentage of patients with asthma between the ages of 14 and 19 years in whom there is a record of smoking status in the preceding 15 months	6	45-80%		Asthma 3 renumbered as Asthma 10 following a change to the business rules to include a new exception cluster. Review use of exceptions. Ensure achievement of new threshold
ASTHMA 6		ASTHMA 6 re-numbered as ASTHMA 9 to include 3 RCP questions				
Lower threshold has increased from 40% to 45%		ASTHMA 9. The percentage of patients with asthma who have had an asthma review in the preceding 15 months that includes an assessment of asthma control using the 3 RCP questions	20	45-70%		New indicator. Similar to 2011/12 ASTHMA6 but with addition of an assessment of asthma control using the 3 RCP questions. Ensure achievement of new threshold Ensure 3 RCP questions are on review template and being used consistently by clinicians. Audit whether any particular

						clinician is missing this element of the review
Dementia						
Comments on prevalence and exception reporting:						
		Records				
		DEM 1. The practice can produce a register of patients diagnosed with dementia	5			
		Ongoing management				
Lower threshold has increased from 25% to 35% and upper threshold has increased from 60% to 70%		DEM 2. The percentage of patients diagnosed with dementia whose care has been reviewed in the previous 15 months	15	35-70%		Ensure achievement of new threshold
DEM3.		DEM3. Renumbered as DEM4				
Lower threshold has increased from 40% to 45%		DEM4. The percentage of patients with a new diagnosis of dementia recorded between the preceding 1 April to 31 March with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded 6 months before or after entering on to the register *NICE 2010 menu ID: NM09*	6	45-80%		New indicator. Renumbered DEM3 Ensure achievement of new threshold
Depression						
Comments on prevalence and exception reporting:						
		Records				
Lower threshold has increased		DEP 1. The percentage of patients on	6	50-90%		Ensure achievement of new

from 40% to 50%		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				threshold
DEP 4.		DEP 4. Re-numbered as DEP6				
Lower threshold has increased from 40% to 50%		DEP6. In those patients with a new diagnosis of depression, recorded between the preceding 1 April to 31 March, the percentage of patients who have had an assessment of severity at the time of diagnosis using an assessment tool validated for use in primary care *NICE 2010 menu ID: NM10*	17	50-90%		New indicator. Re-numbered from DEP4. Ensure achievement of new threshold
DEP 5.		DEP 5. Re-numbered as DEP7				
Lower threshold has increased from 40% to 45%		DEP 7. 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 2 - 12 weeks (inclusive) after the initial recording of the assessment of severity. Both assessments should be completed using an assessment tool validated for use in primary care *NICE 2010 menu ID: NM11*	8	45-80%		New indicator. Re-numbered from DEP5. Ensure achievement of new threshold
Chronic kidney disease (CKD)						
Comments on prevalence and exception reporting:						

		Records				
		CKD 1. The practice can produce a register of patients aged 18 years and over with CKD (US National Kidney Foundation: Stage 3 to 5 CKD)	6			
		Initial management				
Reduced by 2 points to 4 points in 2012/13 Lower threshold has increased from 40% to 50%		CKD 2. The percentage of patients on the CKD register whose notes have a record of blood pressure in the previous 15 months	4	50-90%		Ensure achievement of new threshold
		Ongoing management				
Lower threshold has increased from 40% to 45%		CKD 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	11	45-70%		Ensure achievement of new threshold
Lower threshold has increased from 40% to 45%		CKD 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)	9	45-80%		Ensure achievement of new threshold
Lower threshold has increased from 40% to 45%		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	45-80%		Ensure achievement of new threshold
Atrial fibrillation						
Comments on prevalence and exception reporting:						
		Records				

		AF 1. The practice can produce a register of patients with atrial fibrillation	5			
		Initial diagnosis				
AF 4. The percentage of patients with atrial fibrillation diagnosed after 1 April 2008 with ECG or specialist confirmed diagnosis		**Retired**				
		Ongoing management				
AF 3. The percentage of patients with atrial fibrillation who are currently treated with anti-coagulation drug therapy or an anti-platelet therapy		**Retired**				
		AF 5. The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHADS2 risk stratification scoring system in the preceding 15 months (excluding those whose previous CHADS2 score is greater than 1) *NICE 2011 menu ID: NM24*	10	40-90%		New Indicator Add this assessment to the review template and ensure flag system is running effectively on the clinical system
		AF6. In those patients with atrial fibrillation in whom there is a record of a CHADS2 score of 1(latest in the preceding 15 months), the percentage of patients who are currently treated with anti-coagulation drug therapy or anti-platelet therapy *NICE 2011 menu ID: NM45*	6	50-905		New Indicator Ensure all clinicians are aware of indicator. Audit achievement regularly by clinician
		AF7. In those patients with atrial fibrillation whose latest record of a CHADS2 score is greater than 1, the percentage of patients who are currently treated with anti-coagulation therapy	6	40-70%		New Indicator Ensure all clinicians are aware of indicator Audit achievement regularly by clinician

		NICE 2011 menu ID: NM46				
Obesity						
Comments on prevalence and exception reporting:						
		Records				
		OB 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	8			
Learning disability						
Comments on prevalence and exception reporting:						
		Records				
		LD 1. The practice can produce a register of patients aged 18 and over with learning disabilities	4			
Lower threshold has increased from 40% to 45%		LD2. Percentage of patients on the Learning Disability register with Down's Syndrome aged 18 years and over who have a record of blood TSH in the preceding 15 months (excluding those who are on the thyroid disease register)	3	45-70%		Ensure achievement of new threshold
Smoking						
Comments on prevalence and exception reporting:						
		Ongoing management				
SMOKING 3		SMOKING 3 re-numbered as SMOKING 5				

Reduced by 5 points as SMOKING 3 in 2011/12 to 25 points as SMOKING 5 in 2012/13 Lower threshold has increased from 40% to 50%		SMOKING 5. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 15 months *NICE 2011 menu ID: NM38*	25	50-90%		Ensure achievement of new threshold
SMOKING 4		SMOKING 4 re-numbered as SMOKING 6				
Reduced by 5 points as SMOKING 4 in 2011/12 to 25 points as SMOKING 6 in 2012/13 Lower threshold has increased from 40% to 50%		SMOKING 6. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who smoke whose notes contain a record of an offer of support and treatment within the preceding 15 months *NICE 2011 menu ID: NM39*	25	50-90%		Ensure achievement of new threshold
		SMOKING 7. The percentage of patients aged 15 years and over whose notes record smoking status in the preceding 27 months	11	50-90%		New Indicator Set up flag system on the clinical system to prompt clinicians to ask for this information
		SMOKING 8. The percentage of patients aged 15 years and over who are recorded as current smokers who have a record of an offer of support and treatment	12	40-90%		New Indicator Ensure all clinicians are aware of the treatment and support services available for smoking

		within the preceding 27 months NICE 2011 menu ID: NM40				cessation
Peripheral arterial disease (PAD)						
Comments on prevalence and exception reporting:						
		Records				
		PAD1. The practice can produce a register of patients with peripheral arterial disease *NICE 2011 menu ID: NM32*	2			New Indicator Agree READ codes and communicate to all members of the clinical team
		Ongoing management				
		PAD2. The percentage of patients with peripheral arterial disease with a record in the preceding 15 months that aspirin or an alternative anti-platelet is being taken *NICE 2011 menu ID: NM33*	2	40-90%		New Indicator Agree care pathway and READ codes for these patients and communicate to all members of the clinical team
		PAD3. The percentage of patients with peripheral arterial disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 or less *NICE 2011 menu ID: NM34*	2	40-90%		New Indicator Develop a call/recall system and flag clinical records to prompt blood measurement for these patients
		PAD4. The percentage of patients with peripheral arterial disease in whom the last measured total cholesterol (measured in the preceding 15 months) is 5.0mmol/l or less	3	40-90%		New Indicator Agree care pathway and READ codes for these patients and communicate to all members of the clinical team

		NICE 2011 menu ID: NM35				
Osteoporosis: Secondary prevention of fragility fractures (OST)						
Comments on prevalence and exception reporting:						
		Records				
		OST1. The practice can produce a register of patients: 1. Aged 50-74 years with a record of a fragility fracture after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and 2. Aged 75 years and over with a record of a fragility fracture after 1 April 2012 *NICE 2011 menu ID: NM29*	3			New Indicator Agree READ codes and communicate to all members of the clinical team
		Ongoing management				
		OST2. The percentage of patients aged between 50 and 74 years, with a fragility fracture, in whom osteoporosis is confirmed on DXA scan, who are currently treated with an appropriate bone-sparing agent *NICE 2011 menu ID: NM30*	3	30-60%		New Indicator Agree care pathway and READ codes for these patients and communicate to all members of the clinical team
		OST3. The percentage of patients aged 75 years and over with a fragility fracture, who are currently treated with an appropriate bone-sparing agent *NICE 2011 menu ID: NM31*	3	30-60%		New Indicator Agree care pathway and READ codes for these patients and communicate to all members of the clinical team

Organisational indicators

Changes from 2011/12 indicator	2011/12 achievement	2012/13 indicators	points	Payment stages	Current achievement 2012/13	Action (SMART)
Records						
		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	80%		
		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	65%		
		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	60%		
		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	80%		
		Records 18 The practice has up-to-date clinical summaries in at least 80% of patient records	8	80%		
		Records 19. 80% of newly registered	7	80%		

		patients have had their notes summarised within 8 weeks of receipt by the practice				
		Records 20. The practice has up-to-date clinical summaries in at least 70% of patient records	12	70%		
Records 23 The percentage of patients aged over 15 years whose notes record smoking status in the preceding 27 months		**Retired**				
Information for patients						
		Information 5. The practice supports smokers in stopping smoking by a strategy which includes providing literature and offering appropriate therapy	2			
Education and training						
Education 1		Education 1. re-numbered as Education 11 due to changes to the indicator wording.				
		Education 11. There is a record of all practice-employed clinical staff and clinical partners 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	4			

		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 • admissions under the Mental Health Act • child protection cases • medication errors A significant event occurring when a patient may have been subjected to harm, had the circumstance/outcome been different (near miss)				
		Education 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 3 significant event reviews within the last year	6			
Practice management						
		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: • 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						
		Medicines 2 The practice possesses the equipment and in-date emergency drugs to treat anaphylaxis	2			
		Medicines 3 There is a system for	2			

		checking the expiry dates of emergency drugs on at least an annual basis				
		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	80%		
		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	80%		
Quality and productivity						
QP 1. The practice conducts an internal review of their prescribing to assess whether it is clinically appropriate and cost effective, agrees with the PCO 3 areas for		**Retired**				

improvement and produces a draft plan for each area no later than 30 June 2011						
QP 2. The practice participates in an external peer review of prescribing with a group of practices and agrees plans for 3 prescribing areas for improvement firstly with the group and then with the PCO no later than 30 September 2011		**Retired**				
QP 3. The percentage of prescriptions complying with the agreed plan for the first improvement area as a percentage of all prescriptions in that improvement area during the period 1 January 2012 to 31 March 2012 (Payment stages to be determined locally according to the method set out in the indicator guidance below with 20 percentage points between upper and lower thresholds)		**Retired**				
QP 4. The percentage of prescriptions complying with the agreed plan for the second improvement area as a percentage of all prescriptions in that improvement area during the period 1 January 2012 to 31 March 2012 (Payment stages to be determined locally according to the method set out in the indicator guidance below with 20 percentage points between upper and lower thresholds)		**Retired**				

QP 5. The percentage of prescriptions complying with the agreed plan for the third improvement area as a percentage of all prescriptions in that improvement area during the period 1 January 2012 to 31 March 2012 (Payment stages to be determined locally according to the method set out in the indicator guidance below with 20 percentage points between upper and lower thresholds)		**Retired**				
		QP 6. The practice meets internally to review the data on secondary care outpatient referrals provided by the PCO	5			
		QP 7. The practice participates in an external peer review with a group of practices to compare its secondary care outpatient referral data either with practices in the group of practices or with practices in the PCO area and proposes areas for commissioning or service design improvements to the PCO	5			
		QP 8. The practice engages with the development of and follows 3 agreed care pathways for improving the management of patients in the primary care setting (unless in individual cases they justify clinical reasons for not doing this) to avoid inappropriate outpatient referrals and produces a report of the action taken to the PCO no later than 31 March 2012	11			
		QP 9. The practice meets internally to review the data on emergency	5			

		admissions provided by the PCO				
		QP 10. The practice participates in an external peer review with a group of practices to compare its data on emergency admissions either with practices in the group of practices or practices in the PCO area and proposes areas for commissioning or service design improvements to the PCO	15			
		QP 11. The practice engages with the development of and follows 3 agreed care pathways (unless in individual cases they justify clinical reasons for not doing this) in the management and treatment of patients in aiming to avoid emergency admissions and produces a report of the action taken to the PCO no later than 31 March 2012	27.5			
		QP 12. The practice meets internally to review the data on accident and emergency attendances provided by the PCO no later than 31 July 2012. The review will include consideration of whether access to clinicians in the practices is appropriate, in light of the patterns on accident and emergency attendance	7			
		QP 13. The practice participates in an external peer review with a group of practices to compare its data on accident and emergency attendances, either with practices in the group of practices or practices in the PCO area and agrees an improvement plan firstly with the group and then with the PCO	9			

		no later than 30 September 2012. The review should include, if appropriate, proposals for improvement to access arrangements in the practice in order to reduce avoidable accident and emergency attendances and may also include proposals for commissioning or service design improvements to the PCO				
		QP 14. The practice implements the improvement plan that aims to reduce avoidable accident and emergency attendances and produces a report of the action taken to the PCO no later than 31 March 2013	15			

Patient Experience

Changes from 2011/12 indicator	2011/12 achievement	2012/13 indicators	points	Payment stages	Current achievement 2012/13	Action (SMART)
		PE 1 Length of consultations The length of routine booked appointments with the doctors in the practice is not less than 10 minutes (If the practice routinely sees extras during booked surgeries, then the average booked consultation length should allow for the average number of extras seen in a surgery session. If the extras are seen at the end, then it is not necessary to make this adjustment). For practices with only an open surgery system, the average face to face time spent by the GP with the patient is at least 8 minutes. Practices that routinely operate a mixed economy of booked and open surgeries should report on both criteria	33			

Additional Services

Changes from 2011/12 indicator	2011/12 achievement	2012/13 indicators	points	Payment stages	Current achievement 2012/13	Action (SMART)
Cervical screening (CS)						
Lower threshold has increased from 40% to 45%		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	11	45–80%		Ensure achievement of new threshold
		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)						
		CHS 1 Child development checks are offered at intervals that are consistent with national guidelines and policy	6			
Maternity services (MAT)						
		MAT 1 Ante-natal care and screening are offered according to current local guidelines	6			

Contraception (SH)						
		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			
Lower threshold has increased from 40% to 50%		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 (LARC) in the previous 15 months.	3	50–90%		Ensure achievement of new threshold
Lower threshold has increased from 40% to 50%		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.	3	50–90%		Ensure achievement of new threshold