



Primary Care Contracting

QOF Management Guide

Volume 3

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QUALITY AND OUTCOMES FRAMEWORK (QOF) MANAGEMENT GUIDE: VOLUME 3

This is one of a suite of 3 documents; **Volume 1** is a simple iterative guide to QOF, function and purposes; **Volume 2** is an in depth guide to developing and delivering high class QOF assessment, with a large section on information management, uses, tools and analyses;

Volume 3 - this guide - is a performance guide to each individual QOF indicator for 2008 - 09, with best practice and individual indicator assessment tips. Whilst each document stands alone, there are cross-references within them and the intention overall is to achieve a complete guide. Volume 3 will be updated in time for the 2009-10 changes to QOF.

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How to use this Guide

The guide provides an indicator by indicator description of the clinical indicators together with frequently asked questions and assessment tips. It is divided by QOF clinical area. This document is supplemental to the [2008 -09 QOF guidance from NHS Employers/GPC](#)

Information in each clinical area is presented in the following format:

- A table of the current indicators together with associated points and payment thresholds
- National prevalence figures for each QOF year so far
- A guide to the interpretation and assessment of each indicator, including achievement at the national level, in terms of points and percentage of patients covered.

Within the indicator guide is a narrative description of the Business Rule and Dataset which supports payment through QMAS. These reflect [version 12 of the rule sets](#) ie those published in summer 2008. These are updated twice a year. An update to this document will be published when version 13 of the rule sets are released.

Achievement information for each indicator is presented as a table which shows the percentage of points achieved together with the underlying percentage achievement at a national (England) level. The percentage of points achieved is calculated by dividing the total points achieved by all practices, by the total points available for this indicator, and expressing it as a percentage. The underlying percentage achievement is calculated by dividing the total number of patients in the numerator by the total number of patients in the denominator and expressing this as a percentage. Patients who have been exception reported are excluded from this calculation. The explanation of this calculation is provided for completeness but not for local action. The information used to calculate this is available from the [NHS Information Centre](#)

This document which refers to the 2008-09 QOF will be updated in line with changes to the framework, revisions to the rule sets and frequently asked questions. Indicators that change in 2009-10 are annotated, although all the 2009-10 are not described in the text. These can be accessed at the [NHS employers QOF pages](#)

Secondary Prevention of Coronary Heart Disease

Indicator	Points	Payment Stages
Records		
CHD1: The practice can produce a register of patients with coronary heart disease	4	
Initial Diagnosis		
CHD2: 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		
CHD5: The percentage of patients with coronary heart disease whose notes have a record of blood pressure in the previous 15 months	7	40 - 90%
CHD6: 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	19	40 - 70%
CHD7: The percentage of patients with coronary heart disease whose notes have a record of total cholesterol in the previous 15 months	7	40 - 90%
CHD8: 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%
CHD9: 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 anticoagulant is being taken (unless a contraindication or side effects are recorded)	7	40 - 90%
CHD10: 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%
CHD11: 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%
CHD12: 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%

Prevalence

Year	Sum of Register Counts	Unadjusted Prevalence
2007 - 2008	1,892,432	3.5%
2006 - 2007	1,898,565	3.5%
2005 - 2006	1,900,640	3.6%
2004 - 2005	1,893,184	3.6%

Indicator Detail

CHD1: The practice can produce a register of patients with coronary heart disease

Key points to note - There are no key points to note in relation to this register. As with all registers, assessors should discuss with practices their processes for ensuring that the register is complete and accurate. See Annex for West Midlands register standards.

CHD2: The percentage of patients with newly diagnosed angina (diagnosed after 1 April 2003) who are referred for exercise testing and/or specialist assessment

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	96.3%	94.5%
2006 - 2007	94.3%	93.4%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see if the patient has a diagnosis of angina in their record. If there is no record of the patient having angina then they are excluded from the denominator. Exclusion is conceptually different to a patient being exception reported. Patients who are excluded are not eligible for the care described in the indicator.
Rule 2	This rule checks that the date of the earliest episode of angina is after the 1 April 2003. If it was before this date then the patient is excluded as their diagnosis predates the introduction of QOF.
Rule 3	This rule checks that the date of the exercise testing is within the accepted timeframe. In this case up to 3 months before or 12 months after the date of the earliest recording of an angina diagnosis. If this is true then the patient is selected into the denominator.
Rule 4	This rule checks to see if the patient has registered with the practice in the last 3 months. If they have then this is an acceptable reason for the patient to be excepted from the denominator.
Rule 5	This rule checks to see if a coronary heart disease exception reporting code has been entered into the record in the last 15 months. If this is present then the patient is excepted from the denominator.
Rule 6	This rule checks to see if an exercise test exception code has been added to the record. The acceptable timeframe for this is up to 12 months after the earliest recording of the angina diagnosis. If this is present then the patient is excepted from the denominator.
Rule 7	This rule checks to see whether the diagnosis of angina is recent ie within the last 3 months. If this is the case then the patient can be excepted from the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks that the date of the exercise testing is within the accepted timeframe. In this case up to 3 months before or 12 months after the date of the earliest recording of an angina diagnosis. If this is true then the patient is selected into the numerator. If not they are counted as a failure against the indicator.
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Known concerns/ queries - There are no known concerns/ queries against this indicator.

CHD5: The percentage of patients with coronary heart disease whose notes have a record of blood pressure in the previous 15 months

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	99.8%	98.0%
2006 - 2007	99.7%	98%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks that there is a record of a blood pressure recording in the last 15 months. If there is then the patient is selected into the denominator.
Rule 2	This rule checks to see if there is a record of a BP exception code in the last 15 months. If this is present then the patient can be excepted from the denominator.
Rule 3	This rule checks to see if the patient has registered with the practice in the last 3 months. If they have then this is an acceptable reason for the patient to be excepted from the denominator.
Rule 4	This rule checks to see if a CHD exception reporting code has been entered into the record in the last 15 months. If it has then the patient is excepted from the denominator.
Rule 5	This rule checks to see if the diagnosis of CHD is recent ie within the last 3 months. If this is the case then the patient can be excepted from the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks that there is a record of blood pressure recording in the last 15 months. If there is then the patient is selected into the numerator. If not, then the patient will not be counted in achievement against the indicator.
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Known concerns/ queries - There are no known concerns/ queries against this indicator.

Issues for assessment - Assessors should check that entries in support of this indicator can be linked to evidence of a consultation within the patient record. This should take the form of either a face to face consultation or a letter detailing that a blood pressure measurement has been performed together with its associated values. Good clinical practice is for an annual check for the patient; the 15 months cited in the indicator is to allow latitude for patients and the practice for measurement.

CHD6: 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

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	99.8%	89.4%
2006 - 2007	99.7%	88.9%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	<p>This rule checks for three attributes, all of which must be true in order for the patient to be selected into the denominator.</p> <ul style="list-style-type: none"> • Firstly that the latest systolic blood pressure is less than or equal to 150 mm/mg, • secondly that the latest diastolic blood pressure is less than or equal to 90mm/mg and • finally, that this recording has been made within the previous 15 months. <p>If any of these criteria are not met then the record is examined against the subsequent rules to see if there is a reason for the patient not to be included in the denominator.</p>
Rule 2	<p>This rule checks to see if a blood pressure exception reporting code has been entered into the record in the last 15 months. If this is present then the patient is excepted from the denominator.</p>

Rule 3	This rule checks to see if the patient has registered with the practice in the last 9 months. If they have then this is an acceptable reason for the patient to be excepted from the denominator.
Rule 4	This rule checks to see if a CHD exception code has been entered into the patient record within the last 15 months. If it has then the patient can be excepted from the denominator.
Rule 5	This rule checks to see if the patient has been recently diagnosed ie within the last 9 months. If they have then they can be excepted from the denominator.
Rule 6	This rule checks to see if the patient has been recorded as being on maximal therapy for blood pressure control within the last 15 months. If they have then they can be excepted from the indicator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks for three attributes, all of which must be true in order for the patient to be selected into the denominator. Firstly that the latest systolic blood pressure is less than or equal to 150 mm/mg, secondly that the latest diastolic blood pressure is less than or equal to 90mm/mg and finally, that this recording has been made within the previous 15 months. If any of these criteria are not met then the patient is counted as a failure against the indicator
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Known issues/ queries -

Why is the time frame for recent diagnosis 9 months rather than 3 months?

The accepted timeframes for recent diagnosis are detailed on page 6 of the QOF Guidance. This states: “..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”. As this indicator relates to the delivery of clinical standards (which cannot be immediately delivered, but will be through progressing normal clinical care) then newly diagnosed or registered patients can be exception reported for 9 months.

Issues for assessment - Assessing maximal blood pressure therapy can be challenging and should be carried out by a clinical assessor. Discussions with clinical assessors suggest that the number of patients excepted for this reason should be low and each decision should be supported by extensive free text detailing the rationale for this decision in the patient record. Good clinical practice is for an annual check for the patient; the 15 months cited in the indicator is to allow latitude for patients and the practice for measurement.

CHD7: The percentage of patients with coronary heart disease whose notes have a record of total cholesterol in the previous 15 months

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	98.6%	94.1%
2006 - 2007	98.5%	94.1%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see if the date of the latest cholesterol test is within the last 15 months. If it is then the patient is selected into the denominator.
Rule 2	This rule checks to see if the patient has registered with the practice in the last 3 months. If they have then this is an acceptable reason for the patient to be excepted from the denominator.
Rule 3	This rule checks to see if a CHD exception code has been added to the patient record in the last 15 months. If this is present then the patient is excepted from the denominator.
Rule 4	This rule checks to see if the diagnosis of CHD is recent ie within the last 3 months. If this is the case then the patient can be excepted from the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks to see if the date of the latest cholesterol test is within the last 15 months. If it is then the patient is selected into the numerator. If it is not then the patient is counted as a failure against the indicator.
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Known issues/ queries - There are no known issues with this indicator

Issues for assessment - There are no significant issues for assessment associated with this indicator. Again assessors are reminded that each entry in support of this indicator should be supported by evidence of a consultation within the patient record. Although the indicator is for fifteen months, good clinical practice is for cholesterol to be checked annually; the 15 months cited in the indicator is to allow latitude for patients and the practice for measurement.

CHD8: The percentage of patients with coronary heart disease, whose last measured total cholesterol (measured in the previous 15 months) is 5mmol/l or less.

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	98.9%	82.5%
2006 - 2007	98.3%	81.9%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks for two attributes, both of which must be true for the patient to be selected into the denominator. Firstly it checks to see if the value of the latest cholesterol measurement is less than or equal to 5mmol/l. Secondly it check to see if that test has been performed in the last 15 months. If these are both true then the patient is selected into the denominator.
Rule 2	This rule checks to see if the patient has registered with the practice in the last 9 months. If they have then this is an acceptable reason for the patient to be excepted from the denominator.
Rule 3	This rule checks to see if a CHD exception code has been added to the patient record in the last 15 months. If this is present then the patient is excepted from the denominator.

Rule 4	This rule checks to see if the diagnosis of CHD is recent ie within the last 9 months. If this is the case then the patient can be excepted from the denominator.
Rule 5	This rule checks to see if there is a persistent exception code for serum cholesterol target recorded ever, or if there is an expiring exception code for serum cholesterol target recorded in the last 15 months. If either of these is present then the patient is excepted from the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks for two attributes, both of which must be true for the patient to be selected into the numerator. Firstly it checks to see if the value of the latest cholesterol measurement is less than or equal to 5mmol/l. Secondly it check to see if that test has been performed in the last 15 months. If one or other of these attributes is not met then the patient is counted as a failure against the indicator.
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Known concerns/ queries - There are no known concerns/ queries regarding this indicator.

Issues for assessment - There are no specific issues for assessment relating to this indicator. Assessors are reminded that it is best practice that expiring and persisting contraindication codes are supported by free text giving the rationale for this decision. Although the indicator is for fifteen months, good clinical practice is for maintenance of lowered cholesterol to be checked annually; the 15 months cited in the indicator is to allow latitude for patients and the practice for measurement.

CHD9: 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 anticoagulant is being taken (unless a contraindication or side effects are recorded)

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	99.4%	94.4%
2006 - 2007	99.1%	94.4%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks that there is a record of aspirin, an alternative anti-platelet or an anti-coagulant having been prescribed within the previous 15 months. If there is then the patient is selected into the denominator.
Rule 2	This rule checks to see if the patient has registered with the practice in the last 3 months. If they have then this is an acceptable reason for the patient to be excepted from the denominator.
Rule 3	This rule checks to see if a CHD exception code has been added to the patient record in the last 15 months. If this is present then the patient is excepted from the denominator.
Rule 4	This rule checks to see if the diagnosis of CHD is recent ie within the last 3 months. If this is the case then the patient can be excepted from the denominator.
Rule 5	This rule checks to see if there are any expiring or persistent salicylate contraindication codes in the record. If neither code is present then the patient is selected into the denominator. If not then the next rule is applied.
Rule 6	This rule checks to see that there is no persisting salicylate contraindication code and to see if any expiring salicylate contraindication code has been entered into the record in the last 15 months. If the expiring contraindication code was added before this time then the patient is selected into the denominator. If not then the next rule is applied.

Rule 7	This rule checks to see if there are any expiring or persistent warfarin exception codes in the record. If neither code is present then the patient is selected into the denominator. If not then the next rule is applied.
Rule 8	This rule checks to see that there is no persisting contraindication code for warfarin and that any expiring code for warfarin contraindications has been entered into the record in the last 15 months. If the expiring contraindication code was added before this time then the patient is selected into the denominator. If not then the next rule is applied.
Rule 9	This rule checks to see if there are any expiring or persistent clopidogrel contraindication codes in the record. If neither code is present then the patient is selected into the denominator. If not then the next rule is applied.
Rule 10	This rule checks to see that there is no persisting contraindication to clopidogrel and that any expiring contraindication code has been entered into the record in the last 15 months. If the expiring contraindication code was added before this time then the patient is selected into the denominator. If not then the next rule is applied.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks that there is a record of aspirin, an alternative anti-platelet or an anti-coagulant having been prescribed within the previous 15 months. If there is then the patient is selected into the numerator. If not then the patient is counted as a failure against the indicator.
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Known concerns/ queries - Practices are reminded that an intolerance or contraindication should be added for each of the named anti-platelet or anti-coagulation therapy as appropriate. Where a patient is not on an anti-platelet or anti-coagulant therapy and there is not a record of a contraindication to all of the stipulated therapies then the patient will be included in the denominator and will count as a failure against the indicator.

Issues for assessment - There are no specific issues for assessment related to this indicator. Although the indicator is for fifteen months, good clinical practice is for treatment to be checked annually; 15 months is allowed to give leeway for checking.

CHD10: The percentage of patients with coronary heart disease who are currently treated with a beta blocker (unless a contraindication or side effects are recorded)

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	98.4%	72.7%
2006 - 2007	97.1%	72.2%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see if there is a record of the patient having been given a prescription for beta blockers in the last 6 months. If this is the case then the patient is selected into the denominator. If not then the next rule is applied.
Rule 2	This rule checks to see if the patient has registered with the practice in the last 3 months. If this is the case then they are exception reported from the denominator. If not then the next rule is applied.
Rule 3	This rule checks to see if a CHD exception reporting code has been entered into the record in the last 15 months. If this is the case then the patient is exception reported. If not then the next rule is applied.
Rule 4	This rule checks to see if the earliest recording of the diagnosis of heart disease is in the last 3 months. If this is the case then the patient is exception reported. If not then the next rule is applied.
Rule 5	This rule checks to see if there is a persisting contraindication to beta blocker therapy recorded in the patient record. If this is present then the patient is rejected from the denominator. If not then the next rule is applied.
Rule 6	This rule checks to see if there is an expiring contraindication to beta blocker therapy entered in the patient record in the last 15 months. If this is the case then the patient is excepted from the denominator. All remaining records should be selected into the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks to see if there is a record of the patient having been given a prescription for beta blockers in the last 6 months. If this is the case then the patient is selected into the numerator. If not then the patient is counted as a failure against the indicator.
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Known concerns/queries - There are no known concerns/queries related to this indicator.

Issues for assessment - There are no specific issues for assessment related to this indicator.

CHD11: 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

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	98.6%	89.9%
2006 - 2007	98.2%	90.2%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see if the patient has had an MI since the 1st April 2003. If this is not the case then the record is excluded from the denominator. If it is the case then the next rule is applied.
Rule 2	This rule checks to see if there is a record of either a ACE or a A2 antagonist having been prescribed in the last 6 months. If this is the case then the patient is selected into the denominator. If not then the next rule is applied.
Rule 3	This rule checks to see if the patient has registered with the practice in the last 3 months. If this is the case then they are excepted from the denominator. If not then the next rule is applied.
Rule 4	This rule checks to see if a CHD exception reporting code has been entered in to the record in the last 15 months. If this is the case then they are excepted from the denominator. If not then the next rule is applied.
Rule 5	This rule checks to see if the latest diagnosis of an MI is within the last 3 months. If this is the case then the patient is exception reported. If not then the next rule is applied.
Rule 6	This rule checks to see if there is a code for either an expiring or persisting ACE contraindication entered into the record. If neither code is present then the patient is selected into the denominator. If not, then the next rule is applied.
Rule 7	This rule checks to see that there is no code for a persisting ACE contraindication and that the code for an expiring ACE contraindication has been entered within the last 15 months. If this code has been entered before this timeframe then the patient is selected into the denominator.
Rule 8	This rule checks to see if there is a code for either an expiring or persisting A2 antagonist contraindication entered into the record. If neither code is present then the patient is selected into the denominator. If not, then the next rule is applied.
Rule 9	This rule checks to see that there is no code for a persisting A2 antagonist contraindication and that the code for an expiring A2 antagonist contraindication has been entered within the last 15 months. If this code has been entered before this timeframe then the patient is selected into the denominator. All remaining records are rejected from the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks to see if there is a record of either an ACE or a A2 antagonist having been prescribed in the last 6 months. If this is the case then the patient is selected into the numerator. If not then the patient is counted as a failure against the indicator.
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Known concerns/ queries - Again practices and assessors are reminded that contraindication codes should be added for both ACE inhibitors and A2 antagonists if relevant. Otherwise if the patient is not prescribed either medication then they will be selected into the denominator but will not count towards the numerator.

Issues for assessment - There are no specific issues for assessment related to this indicator.

CHD12: The percentage of patients with coronary heart disease who have a record of influenza immunisation in the preceding 1 September to 31 March

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	97.7%	92.2%
2006 - 2007	97.2%	92.3%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see if the date of the latest flu vaccination is on or after the 1st September and on or before the 31st March. If both these criteria are met then the patient is selected into the denominator. If not the next rule is applied.
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Rule 2	This rule checks to see if the patient has registered with the practice in the last 3 months. If so then the patient can be exception reported. If not then the next rule is applied.
Rule 3	This rule checks to see if a CHD exception reporting code has been added to the record in the last 15 months. If so then the patient can be exception reported. If not then the next rule is applied.
Rule 4	This rule checks to see if the date of the earliest CHD diagnosis is within the last 3 months. If this is the case then the patient can be exception reported. If not then the next rule is applied.
Rule 5	This rule checks to see if a persisting flu vaccination contraindication code has been added to the record. If so the patient is exception reported from the denominator. If not the next rule is applied.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks to see if the date of the latest flu vaccination is on or after the 1st September and on or before the 31st March. If both these criteria are met then the patient is selected into the numerator. If not the patient is counted as a failure against the indicator.
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Known concerns/ queries - There are no known concerns/ queries related to this indicator.

Issues for assessment - There are no specific issues for assessment related to this indicator.

Heart Failure Indicator Set

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%

Prevalence

Year	Sum of Register Counts	Unadjusted Prevalence
2007 - 2008	406,668	0.8%
2006 - 2007	419,856	0.8%

Indicator Detail

HF1: The practice can produce a register of patients with heart failure

Key Points to note

The register should include all patients with heart failure. This change was introduced in 2006 when heart failure became a clinical domain in its own right. Prior to this the focus was upon LVD as a subset of the CHD register.

There are two patient populations described within the business rules: those with a diagnosis of heart failure and those with a diagnosis of heart failure due to LVD. Patients in the latter group should be coded as having both heart failure and LVD. Failure to capture both codes will result in the patient not being included in the register and therefore the denominator for HF3. This is required as LVD can be diagnosed in the absence of heart failure and this indicator set focuses upon those with heart failure.

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

Achievement in this indicator at the national level is given below

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	95.5%	96.4%
2006 - 2007	91.3%	97.3%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks that the diagnosis of heart failure was made after the 1st April 2006. Patients diagnosed before this date will appear within the register but will be excluded from the denominator for this indicator.
Rule 2	This rule checks that the echocardiogram or specialist assessment was made during the period covering 3 months before the date of the diagnosis or up to 12 months afterwards. Patients who meet this criteria are selected into the denominator. If not the next rule is applied
Rule 3	This rule checks to see if the patient has registered with the practice in the last 3 months. If they have then this is an acceptable reason for the patient to be excepted from the denominator. If not the next rule is applied.

Rule 4	This rule checks to see if a heart failure exception reporting code has been entered into the record in the last 15 months. If this is present then the patient is excepted from the denominator. If not the next rule is applied.
Rule 5	This rule checks to see if a code for echocardiogram declined has been entered into the record. If it has then the patient is excepted from the denominator. If not the next rule is applied.
Rule 6	This rule checks to see if the diagnosis of heart failure is recent ie within the last 3 months. If this is the case then the patient can be excepted from the denominator. The remaining records are selected into the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks that the echocardiogram or specialist assessment was made during the allowed period ie up to 3 months before the diagnosis date or up to 12 months afterwards. If this has happened then the patient is selected into the numerator. If not they are counted as a failure against the indicator.
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Known concerns/ queries - There are no known concerns or common queries with this indicator.

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

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	98.2%	89.9%
2006 - 2007	97.6%	89.6%

Narrative description of the rule set

This rule set should be applied to the patient population with heart failure due to LVD.

Denominator

Rule 1	This rule checks to see if patients have been prescribed an ACE inhibitor or and ARB in the previous 6 months. If this is the case the patient record is selected into the denominator. If not the next rule is applied.
Rule 2	This checks to see if the patient has registered at the practice within the last 3 months. If this is the case then the patient can be exception reported. If not the next rule is applied.
Rule 3	This rule checks to see if a heart failure exception code has been added to the record in the last 15 months. If this is the case then the patient is excepted from the indicator. If not the next rule is applied.
Rule 4	This rule checks to see if the diagnosis of heart failure was made in the last 3 months. If it was then the patient can be excepted from the indicator. If not the next rule is applied.
Rule 5	This rule checks to see if there is a code for either an expiring or persisting ACE contraindication entered into the record. If neither code is present then the patient is selected into the denominator. If not, then the next rule is applied.
Rule 6	This rule checks to see that there is no code for a persisting ACE contraindication and that the code for an expiring ACE contraindication has been entered within the last 15 months. If this code has been entered before this timeframe then the patient is selected into the denominator.
Rule 7	This rule checks to see if there is a code for either an expiring or persisting A2 antagonist contraindication entered into the record. If neither code is present then the patient is selected into the denominator. If not, then the next rule is applied.
Rule 8	This rule checks to see that there is no code for a persisting A2 antagonist contraindication and that the code for an expiring A2 antagonist contraindication has been entered within the last 15 months. If this code has been entered before this timeframe then the patient is selected into the denominator. All remaining records are rejected from the denominator.

Numerator

This rule set is applied to the denominator population

Rule 1	This rule checks to see if the patient has been prescribed either an ACE inhibitor or an angiotensin receptor blocker in the previous 6 months. If they have then the patient is selected into the numerator.
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Known concerns/ queries**Some patients with LVD being excluded from the denominator for no obvious reason**

- Some queries have been received about in relation to the denominator for HF3 being smaller than the practice expected. This is usually because the practice has not coded patients with LVD as also having heart failure. This will result in them not being included in the practice population for this indicator which requires the presence of both codes.

Exception reporting for contraindications to ACE Inhibitors or Angiotensin Receptor Blockers

- Practices are reminded that contraindication codes for each drug group must be added where relevant, to ensure that patients not taking therapy for these reasons are excepted from the denominator.

Issues for assessment - Heart failure achievement can be triangulated with prescribing of ACE inhibitors and HES. Generally there will be a positive relationship with higher prescribing leading to lower referral and admission (given the expected prevalence).

Generally it might be helpful to look at prescribing of all cardiovascular drugs (including aspirin) at the same time, to get an idea whether the practice is managing this important set of patients well.

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 5mmol/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, clopidigrel, 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%

Prevalence

Year	Sum of Register Counts	Unadjusted Prevalence
2007 - 2008	881,689	1.6%
2006 - 2007	862,873	1.6%
2005 -2006	834,084	1.6%
2004 -2005	782,733	1.5%

Indicator Detail

STROKE1: The practice can produce a register of patients with stroke or TIA

Key Points to note

There are no key points to note in relation to this register. As with all registers, assessors should discuss with practices their processes for ensuring that the register is complete and accurate. See Annex for West Midlands register standards.

STROKE13: The percentage of new patients with a stroke or TIA who have been referred for further investigation

Achievement

This was a new indicator in 2008 and therefore there are no achievement figures available.

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see if the date of the latest, first or new recorded episode of a stroke or TIA is on or after the 1st April 2008. This is because this was the date that the indicator was introduced. If it is then the next rule is applied. If not then the patient is rejected from the denominator as they are not eligible for the care described.
Rule 2	This rule checks to see if the patient has been referred for further investigation in either the three months before the date of the latest episode or up to one month after. If this is so then the patient is selected into the denominator. If not the next rule is applied.
Rule 3	This checks to see if the patient has registered at the practice within the last 3 months. If this is the case then the patient can be exception reported. If not the next rule is applied.
Rule 4	This rule checks to see if a stroke/TIA exception reporting code has been added to the record within the last 15 months. If so then the patient can be exception reported from the denominator. If not then the next rule is applied.

Rule 5	This rule checks to see if further investigation of the stroke or TIA has been declined. A new recording of this code is required for each stroke/ TIA episode where referral is refused. If this code is present for the latest episode then the patient can be exception reported. If not then the next rule is applied.
Rule 6	This rule checks to see if the earliest recording of a stroke or TIA code is within the last 3 months. If this is the case then the patient can be rejected from the denominator. The remaining records are selected into the denominator.

Numerator

This rule set is applied to the denominator population

Rule 1	This rule checks to see if the patient has been referred for further investigation in either the three months before the date of the latest episode or up to one month after. If this is so then the patient is selected into the numerator. If not the record counts as a failure against the indicator.
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Known concerns/ queries - There are no known concerns/ queries with this indicator.

Issues for assessment - There are no specific issues for assessment in relation to this indicator although PCTs should note that referral for further investigation is required for **each new episode** of a stroke or TIA and the revised timeframe in which this activity should be completed.

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

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	99.5%	97.0%
2006 - 2007	99.4%	97.0%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see if the date of the latest blood pressure recording is within the last 15 months. If so the patient is selected into the denominator. If not the next rule is applied.
Rule 2	This rule checks to see if there is a blood pressure exception reporting code in the record in the last 15 months. If so the patient can be exception reported. If not then the next rule is applied.
Rule 3	This checks to see if the patient has registered at the practice within the last 3 months. If this is the case then the patient can be exception reported. If not the next rule is applied.
Rule 4	This rule checks to see if a stroke/ TIA exception reporting code has been added to the record in the last 15 months. If so then the patient can be exception reported. If not, then the next rule is applied.
Rule 5	This rule checks to see if the diagnosis of stroke or TIA is recent ie within the last 3 months. If so then the patient can be exception reported. All remaining records are selected into the denominator.

Numerator

This rule set is applied to the denominator population

Rule 1	This rule checks to see if the date of the latest blood pressure recording is within the last 15 months. If so the patient is selected into the numerator. If not the patient is regarded as a failure against the indicator.
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Known concerns/ queries - There are no known concerns/ queries with this indicator

Issues for assessment - The QOF Assessor Validation Reports provide useful information in assessing the management and monitoring of hypertension, including mapping distribution within the practice population, as described in [QOF Assessor Validation Reports](#), Establishing Accuracy in QOF data; a PCT assessors guide. Good clinical practice is for an annual check for the patient; the 15 months cited in the indicator is to allow latitude for patients and the practice for measurement.

Assessors are reminded that each entry in support of this indicator should be supported by evidence of a consultation within the patient record.

STROKE6: 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

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	99.5%	87.5%
2006 - 2007	99.3%	86.9%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	<p>This rule checks the most recent blood pressure recording against three criteria all of which must be true in order for the patient to be selected into the denominator.</p> <ul style="list-style-type: none"> • Firstly, the figure recorded for the systolic blood pressure must be less than or equal to 150 mm/Hg. • Secondly, the figure recorded for the diastolic blood pressure must be less than or equal to 90 mm/Hg and • finally this blood pressure needs to have been recorded within the last 9 months. <p>If all these criteria are met then the patient is selected into the denominator. If not the next rule is applied.</p>
Rule 2	<p>This rule checks to see if a blood pressure recording exception code has been entered into the patient record in the last 15 months. If this is the case then the patient is excepted from the denominator. If not then the next rule is applied.</p>
Rule 3	<p>This rule checks to see if the patient has registered with the practice in the last 9 months. If they have then this is an acceptable reason for the patient to be excepted from the denominator. If not then the next rule is applied.</p>
Rule 4	<p>This rule checks to see if a stroke/ TIA exception reporting code has been entered into the record in the last 15 months. If this is present then the patient is excepted from the denominator. If not then the next rule is applied.</p>

Rule 5	This rule checks to see if the earliest diagnosis of stroke/ TIA is recent ie within the last 9 months. If this is the case then the patient can be excepted from the denominator. If not then the next rule is applied.
Rule 6	This rule checks to see if there is a record of the patient being on maximal BP therapy in the last 15 months. If this is the case then the patient can be excepted from the denominator. If not the patient is entered into the denominator.

Numerator

This rule set is applied to the denominator population.

Rule 1	<p>This rule checks the most recent blood pressure recording against three criteria all of which must be true in order for the patient to be selected into the numerator.</p> <ul style="list-style-type: none"> • Firstly, the figure recorded for the systolic blood pressure must be less than or equal to 150 mm/Hg. • Secondly, the figure recorded for the diastolic blood pressure must be less than or equal to 90 mm/Hg and • finally this blood pressure needs to have been recorded within the last 9 months. If all these criteria are met then the patient is selected into the numerator. <p>If not then the patient is counted as a failure against the indicator.</p>
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Known concerns/ queries - There are no known concerns/ issues with this indicator.

Issues for assessment - The [QOF Assessor Validation reports](#) provide useful information in assessing the monitoring and management of hypertension. Assessing maximal blood pressure therapy can be challenging and should be carried out by a clinical assessor. Discussions with clinical assessors suggest that the number of patients excepted for this reason should be low and each decision should be supported by extensive free text detailing the rationale for this decision in the patient record. Although the indicator is for fifteen months, good clinical practice is for treatment to be checked annually; 15 months is allowed to give leeway for checking.

STROKE7: The percentage of patients with TIA or stroke who have a record of total cholesterol in the last 15 months

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	96.0%	91.5%
2006 - 2007	95.5%	91.5%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see if the date of the latest cholesterol test is within the last 15 months. If it is then the patient is selected into the denominator. If not, then the next rule is applied.
Rule 2	This rule checks to see if the patient has recently registered with the practice ie within the last 3 months. If so then they can be exception reported. If not then the next rule is applied.
Rule 3	This rule checks to see if a stroke / TIA exception reporting code has been added to the record within the last 15 months. If so then the patient can be exception reported. If not then the next rule is applied.
Rule 4	This rule checks to see if the diagnosis of the earliest episode of stroke/ TIA is within the last 3 months. If so then the patient can be exception reported. All remaining records are selected into the denominator.

Numerator

This rule set is applied to the denominator population.

Rule 1	This rule checks to see if the date of the latest cholesterol test is within the last 15 months. If it is then the patient is selected into the numerator. If not, then the patient is counted as a failure against the indicator.
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Known concerns/ queries - There are no known concerns/ queries in relation to this indicator.

Issues for assessment - There are no specific issues for assessment related to this indicator. Again assessors are reminded that each entry in support of this indicator should be linked to evidence of a consultation or measurement recorded in correspondence from another health care provider within the patient record. Although the indicator is for fifteen months, good clinical practice is for maintenance of lowered cholesterol to be checked annually; 15 months is allowed to give leeway to the patient.

STROKE 8: The percentage of patients with TIA or stroke whose last measured total cholesterol (measured within the previous 15 months) is 5mmol/l or less

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	98.1%	77.0%
2006 - 2007	97.1%	76.2%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks the most recent cholesterol level recording against two criteria both of which must be true in order for the patient to be selected into the denominator. Firstly, the figure recorded for the cholesterol level must be less than or equal to 5mmol/l. Secondly, the date of this test should be within the last 15 months. If both of these criteria are met then the patient is selected into the denominator. If not then the next rule is applied.
Rule 2	This rule checks to see if the patient has recently registered at the practice ie within the last 9 months. If this is the case then the patient can be exception reported from the denominator. If not, then the next rule is applied.

Rule 3	This rule checks to see if a stroke/ TIA exception reporting code has been added to the record in the last 15 months. If so then the patient can be exception reported from the denominator. If not, the next rule is applied.
Rule 4	This rule checks to see if the date of the earliest recording of a stroke or TIA code is within the last 9 months. If so then the patient can be exception reported from the denominator. If not then the next rule is applied.
Rule 5	This rule checks to see if there is either a persisting cholesterol testing exception code in the record or an expiring cholesterol testing exception code added to the record in the last 15 months. If so then the patient can be exception reported. All remaining records are selected into the denominator.

Numerator

This rule set is applied to the denominator population.

Rule 1	<p>This rule checks the most recent cholesterol level recording against two criteria both of which must be true in order for the patient to be selected into the numerator.</p> <ul style="list-style-type: none"> • Firstly, the figure recorded for the cholesterol level must be less than or equal to 5mmol/l. • Secondly, the date of this test should be within the last 15 months. <p>If both of these criteria are met then the patient is selected into the numerator. If not then the patient is counted as a failure against the indicator.</p>
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Known concerns/ queries - There are no known concerns/ queries in relation to this indicator.

Issues for assessment - There are no specific issues for assessment related to this indicator. Although the indicator is for fifteen months, good clinical practice is for maintenance of lowered cholesterol to be checked annually; 15 months is allowed to allow more time for patient and practice for the check to be completed

STROKE12: 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 contraindication or side-effects are recorded)

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	98.6%	94.1%
2006 - 2007	98.1%	94.1%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule seeks to identify those patients who have had a haemorrhagic stroke and to remove them from the denominator. If a patient has had either a non-haemorrhagic stroke or a TIA then the next rule is applied.
Rule 2	This rule checks that the patient has been given a prescription for either an anti-platelet drug or an anti-coagulant drug within the last 15 months. If this is the case then the patient is selected into the denominator. If not then the next rule is applied.
Rule 3	This rule checks to see if the patient has registered with the practice in the last 3 months. If this is the case then the patient can be exception reported. If not then the next rule is applied.
Rule 4	This rule checks to see if a stroke/ TIA exception reporting code has been added to the record in the last 15 months. If this is the case then the patient can be exception reported. If not then the next rule is applied.
Rule 5	This rule checks to see if the date of the earliest non-haemorrhagic stroke or TIA is within the last 3 months. If so the patient can be exception reported. If not then the next rule is applied.
Rule 6	This rule checks to see if there are any expiring or persistent salicylate contraindication codes in the record. If neither code is present then the patient is selected into the denominator. If not then the next rule is applied.

Rule 7	This rule checks to see that there is no persisting salicylate contraindication code and to see if any expiring salicylate contraindication code has been entered into the record in the last 15 months. If the expiring contraindication code was added before this time then the patient is selected into the denominator. If not then the next rule is applied.
Rule 8	This rule checks to see if there are any expiring or persistent warfarin exception codes in the record. If neither code is present then the patient is selected into the denominator. If not then the next rule is applied.
Rule 9	This rule checks to see that there is no persisting contraindication code for warfarin and that any expiring code for warfarin contraindications has been entered into the record in the last 15 months. If the expiring contraindication code was added before this time then the patient is selected into the denominator. If not then the next rule is applied.
Rule 10	This rule checks to see if there are any expiring or persistent clopidogrel contraindication codes in the record. If neither code is present then the patient is selected into the denominator. If not then the next rule is applied.
Rule 11	This rule checks to see that there is no persisting contraindication to clopidogrel and that any expiring contraindication code has been entered into the record in the last 15 months. If the expiring contraindication code was added before this time then the patient is selected into the denominator. If not then the next rule is applied.
Rule 12	This rule checks to see if there are any expiring or persistent dipyridamole contraindication codes in the record. If neither code is present then the patient is selected into the denominator. If not then the next rule is applied.
Rule 13	This rule checks to see that there is no persisting contraindication to dipyridamole and that any expiring contraindication code has been entered into the record in the last 15 months. If the expiring contraindication code was added before this time then the patient is selected into the denominator. All remaining records are rejected from the denominator.

Numerator

This rule set is applied to the denominator population.

Rule 1	This rule checks that the patient has been given a prescription for either an anti-platelet drug or an anti-coagulant drug within the last 15 months. If this is the case then the patient is selected into the numerator. If not then patient is counted as a failure against the indicator.
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Known concerns/ queries - There are no known concerns/ queries in relation to this indicator.

Issues for assessment - Haemorrhagic stroke recording

PCTs have queried recording of strokes as being either haemorrhagic or non-haemorrhagic in nature. Whilst the ability of practices to do this accurately may be limited by the quality of the information received from secondary care, each stroke should be recorded appropriately in the patient record by a member of practice staff who understands the difference and with due regard for the health outcomes of the patient. Given the clinical importance of this entry it should ordinarily be made by a clinician or under the guidance of a clinician.

STROKE10: The percentage of patients with TIA or stroke who have had influenza immunization in the preceding 1 September to 31 March

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	97.2%	89.5%
2006 - 2007	96.6%	89.4%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see if the date of the latest flu vaccination is on or after the 1st September and on or before the 31st March. If both these criteria are met then the patient is selected into the denominator. If not the next rule is applied.
Rule 2	This rule checks to see if the patient has registered with the practice in the last 3 months. If so then the patient can be exception reported. If not then the next rule is applied.

Rule 3	This rule checks to see if a stroke/ TIA exception reporting code has been added to the record in the last 15 months. If so then the patient can be exception reported. If not then the next rule is applied.
Rule 4	This rule checks to see if the date of the earliest stroke or TIA diagnosis is within the last 3 months. If this is the case then the patient can be exception reported. If not then the next rule is applied.
Rule 5	This rule checks to see if a persisting flu vaccination contraindication code has been added to the record. If so the patient is exception reported from the denominator. If not the next rule is applied.
Rule 6	This rule checks to see if an expiring flu vaccination contraindication code has been added to the record in the last 15 months. If this is so then the patient is exception reported. All remaining records are selected into the denominator.

Numerator

This rule set is applied to the denominator population.

Rule 1	This rule checks to see if the date of the latest flu vaccination is on or after the 1st September and on or before the 31st March. If both these criteria are met then the patient is selected into the numerator. If not then the patient is counted as a failure against the indicator.
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Known concerns/ queries - There are no known concerns/ queries in relation to this indicator.

Issues for assessment - There are no specific issues for assessment related to this indicator.

Hypertension

Indicator	Points	Payment Stages
Records		
BP1: The practice can produce a register of patients with established hypertension	6	
Ongoing Management		
BP4: The percentage of patients with hypertension in whom there is a record of the blood pressure in the previous 9 months	20	40 - 90%
BP5: The percentage of patients with hypertension in whom the last recorded blood pressure (measured in the previous 9 months) is 150/90 or less	57	40 - 70%

Prevalence

Year	Sum of Register Counts	Unadjusted Prevalence
2007 - 2008	6,908,055	12.8%
2006 - 2007	6,705,899	12.5%
2005 -2006	6,365,837	12.0%
2004 -2005	5,973,062	11.3%

Indicator Detail

BP1: The practice can produce a register of patients with established hypertension

Key points to note

As detailed in the guidance, this diagnosis should be made according to [BHS Guidelines](#)

BP4: The percentage of patients with hypertension in whom there is a record of the blood pressure in the previous 9 months

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	98.6%	92.2%
2006 - 2007	98.6%	92.4%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see if the date of the most recent blood pressure recording is within the last 9 months. If it is then the patient is selected into the denominator. If not then the next rule is applied.
Rule 2	This rule checks to see if a blood pressure exception reporting code has been added to the patient record in the last 15 months. If it has then the patient is exception reported from the denominator. If not then the next rule is applied.
Rule 3	This rule checks to see if the patient has registered with the practice in the last 3 months. If they have then this is an acceptable reason for the patient to be excepted from the denominator. If not then the next rule is applied.
Rule 4	This rule checks to see if a hypertension exception reporting code has been entered into the record in the last 15 months. If this is present then the patient is excepted from the denominator. If not then the next rule is applied.
Rule 5	This rule checks to see if the diagnosis of hypertension is recent ie within the last 3 months. If this is the case then the patient can be excepted from the denominator. If not the patient is selected into the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks to see if the date of the most recent blood pressure recording is within the last 9 months. If this is the case then the patient is selected into the numerator. If not they are counted as a failure against the indicator.
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Known concerns/ queries - There are no known concerns/ queries in relation to this indicator.

Issues for assessment - The [QOF Assessor Validation report](#) has been commissioned to support PCTs in the monitoring and assessment of hypertension management. Assessors are reminded that each entry in support of this indicator should be linked to evidence of a consultation within the patient record.

BP5: The percentage of patients with hypertension in whom the last recorded blood pressure (measured in the previous 9 months) is 150/90 or less

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	98.8%	78.3%
2006 - 2007	98.0%	77.6%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks the most recent blood pressure recording against three criteria all of which must be true in order for the patient to be selected into the denominator.
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	Firstly, the figure recorded for the systolic blood pressure must be less than or equal to 150 mm/Hg. Secondly, the figure recorded for the diastolic blood pressure must be less than or equal to 90 mm/Hg and finally this blood pressure needs to have been recorded within the last 9 months. If all these criteria are met then the patient is selected into the denominator. If not the next rule is applied.
Rule 2	This rule checks to see if a blood pressure recording exception code has been entered into the patient record in the last 15 months. If this is the case then the patient is excepted from the denominator. If not then the next rule is applied.
Rule 3	This rule checks to see if the patient has registered with the practice in the last 9 months. If they have then this is an acceptable reason for the patient to be excepted from the denominator. If not then the next rule is applied.
Rule 4	This rule checks to see if a hypertension exception reporting code has been entered into the record in the last 15 months. If this is present then the patient is excepted from the denominator. If not then the next rule is applied.
Rule 5	This rule checks to see if the diagnosis of hypertension is recent ie within the last 9 months. If this is the case then the patient can be excepted from the denominator. If not then the next rule is applied.
Rule 6	This rule checks to see if there is a record of the patient being on maximal BP therapy in the last 15 months. If this is the case then the patient can be excepted from the denominator. If not the patient is entered into the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population.

Rule 1	<p>This rule checks the most recent blood pressure recording against three criteria all of which must be true in order for the patient to be selected into the denominator.</p> <ul style="list-style-type: none"> • Firstly, the figure recorded for the systolic blood pressure must be less than or equal to 150 mm/Hg. • Secondly, the figure recorded for the diastolic blood pressure must be less than or equal to 90 mm/Hg and • finally this blood pressure needs to have been recorded within the last 9 months. If this is the case then the patient is entered into the numerator. If not then the patient is treated as a failure against the indicator.
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Known issues/ queries - There are no known concerns/ queries in relation to this indicator.

Issues for assessment - A [QOF Assessor Validation report](#) has been commissioned to support PCTs in the assessment of the monitoring and management of hypertension. Assessing maximal blood pressure therapy can be challenging and should be carried out by a clinical assessor. Discussions with clinical assessors suggest that the number of patients excepted for this reason should be low and each decision should be supported by extensive free text detailing the rationale for this decision in the patient record.

Although this is a 9 month indicator, [BHS guidelines](#) say that a "six monthly review is probably sufficient when treatment and blood pressure are stable". 9 months cited in the indicator is only to allow latitude for patients and the practice for measurement

Diabetes Mellitus

Indicator	Points	Payment Stages
Records		
DM19: 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		
DM2: The percentage of patients with diabetes whose notes record BMI in the previous 15 months	3	40 - 90%
DM5: The percentage of patients with diabetes who have a record of HbA1c or equivalent in the previous 15 months	3	40 - 90%
DM20: The percentage of patients with diabetes in whom the last HbA1c is 7.5 or less (or equivalent test/ reference range depending upon local laboratory) in the previous 15 months	17	40 - 50%
DM7: The percentage of patients with diabetes in whom the last HbA1c is 10 or less (or equivalent test/ reference range depending on local laboratory) in the previous 15 months	11	40 - 90%
DM21: The percentage of patients with diabetes who have a record of retinal screening in the previous 15 months	5	40 - 90%
DM9: 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%
DM10: The percentage of patients with diabetes with a record of neuropathy testing in the previous 15 months	3	40 - 90%
DM11: The percentage of patients with diabetes who have a record of the blood pressure in the previous 15 months	3	40 - 90%
DM12: The percentage of patients with diabetes in whom the last blood pressure is 145/85 or less	18	40 - 60%
DM13: 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%
DM22: 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%
DM15: 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 - 90%

DM16: The percentage of patients with diabetes who have a record of total cholesterol in the previous 15 months	3	40 - 90%
DM17: The percentage of patients with diabetes whose last measured total cholesterol within the previous 15 months is 5mmol/l or less	6	40 - 70%
DM18: The percentage of patients with diabetes who have had influenza immunisation in the preceding 1 September to 31 March	3	40 - 85%

Prevalence

Year	Sum of Register Counts	Unadjusted Prevalence
2007 - 2008	2,088,335	3.9%
2006 - 2007	1,961,976	3.7%
2005 -2006	1,890,663	3.6%
2004 -2005	1,766,391	3.3%

Indicator Detail

DM19: 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

Key Points to note

The nature of this indicator changed from 1st April 2006 in that a new requirement was added. From this date to be included on the diabetes register then the patient record needed to specify whether the patient has Type 1 or Type 2 diabetes and the accepted Read codes were amended in line with this. Patients whose records do not specify the type of diabetes will not be included in the register. This requirement applies to all diagnoses, not just those after 1st April 2006. It was recognised during negotiations that this may require practices to undertake additional coding.

Therefore, whilst other register points were reduced, the points associated with the diabetes register remained unchanged in 2006 in recognition of the work involved. Where PCTs have observed a fall in register size between 2005/06 and 2006/07 they are advised to confirm that recoding has taken place. Many indicators in this section are for fifteen months, good clinical practice is for annuality; 15 months are allowed to give leeway for measurement and checking.

DM2: The percentage of patients with diabetes whose notes record BMI in the previous 15 months

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	99.0%	94.9%
2006 - 2007	98.9%	95.1%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see that the date of the latest BMI recording is within the last 15 months. If so then the patient is selected into the denominator. If not, then the next rule is applied.
Rule 2	This rule checks to see if the patient has registered with the practice in the last 3 months. If so then the patient can be exception reported. If not then the next rule is applied.
Rule 3	This rule checks to see if a diabetes exception reporting codes has been entered into the record in the last 15 months. If so the patient can be exception reported. If not then the next rule is applied.
Rule 4	This rule checks to see that the earliest diagnosis of diabetes is within the last 3 months. If so then the patient can be exception reported. All remaining records are selected into the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks to see that the date of the latest BMI recording is within the last 15 months. If so then the patient is selected into the numerator. If not, then the patient is counted as a failure against the indicator.
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Known issues/ queries - There are no known concerns/ queries in relation to this indicator.

Issues for assessment - There are no specific issues for assessment in relation to this indicator. Assessors are reminded that each entry in support of this indicator should be linked to evidence of a consultation within the patient record.

DM5: The percentage of patients with diabetes who have a record of HbA1c or equivalent in the previous 15 months

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	99.6%	97.1%
2006 - 2007	99.4%	97.1%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks that the date of the latest HbA1C test is within the last 15 months. If so then the patient is selected into the denominator. If not, then the next rule is applied.
Rule 2	This rule checks that the date of latest fructosamine test is within the last 15 months. If so then the patient is selected into the denominator. If not then the next rule is applied.

Rule 3	This rule checks to see if the patient has registered at the practice within the last 3 months. If so then the patient can be exception reported. If not, then the next rule is applied.
Rule 4	This rule checks to see if a diabetes exception reporting code has been entered into the record in the last 15 months. If so then the patient can be exception reported. If not then the next rule is applied.
Rule 5	This rule checks to see if the earliest diagnosis of diabetes is within the last 3 months. If so then the patient can be exception reported. All remaining records are selected into the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for west Midlands register standards.

Rule 1	This rule checks that the date of the latest HbA1C test is within the last 15 months. If so then the patient is selected into the numerator. If not, then the next rule is applied.
Rule 2	This rule checks that the date of latest fructosamine test is within the last 15 months. If so then the patient is selected into the numerator. If not then the patient is counted as a failure against the indicator.

Known issues/ queries - There are no known concerns/ queries in relation to this indicator.

Issues for assessment - There are no specific issues for assessment in relation to this indicator. Good clinical practice is for at least an annual check for the patient and in practice this may be much more frequent; the 15 months cited in the indicator is to allow latitude for patients and the practice for measurement.

DM20: The percentage of patients with diabetes in whom the last HbA1c is 7.5 or less (or equivalent test/ reference range depending on local laboratory) in the previous 15 months¹

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	98.3%	66.8%
2006 - 2007	97.9%	67.6%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks the most recent HbA1C recording against two criteria, both of which must be true in order for the patient to be selected into the denominator. Firstly, the figure recorded for the HbA1C value must be less than or equal to 7.5 and secondly this test needs to have been recorded within the last 15 months. If both these criteria are met then the patient is selected into the denominator. If not, the next rule is applied.
Rule 2	This rule checks the most recent fructosamine recording against two criteria, both of which must be true in order for the patient to be selected into the denominator. Firstly, the figure recorded for the fructosamine value must be less than or equal to 346 and secondly this test needs to have been recorded within the last 15 months. If both these criteria are met then the patient is selected into the denominator. If not, the next rule is applied.
Rule 3	This rule checks to see if the patient has registered with the practice in the last 9 months. If so then the patient can be exception reported. If not, then the next rule is applied.
Rule 4	This rule checks to see if a diabetes exception code has been entered into the record in the last 15 months. If so then the patient can be exception reported. If not, then the next rule is applied.

¹ For 2009-10 DM 20 (which has a HbA1C target of 7.5 or less) will be replaced by 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 points; thresholds 40 – 50%)

Rule 5	This rule checks to see if the earliest recording of the diabetes diagnosis is within the last 9 months. If so then the patient can be exception reported. If not, then the next rule is applied.
Rule 6	This rule checks to see if a code for maximal diabetes therapy has been entered into the record in the last 15 months. If so then the patient can be exception reported. All remaining records are selected into the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population.

Rule 1	This rule checks the most recent HbA1C recording against two criteria, both of which must be true in order for the patient to be selected into the numerator. Firstly, the figure recorded for the HbA1C value must be less than or equal to 7.5 and secondly this test needs to have been recorded within the last 15 months. If both these criteria are met then the patient is selected into the numerator. If not, the next rule is applied.
Rule 2	This rule checks the most recent fructosamine recording against two criteria, both of which must be true in order for the patient to be selected into the numerator. Firstly, the figure recorded for the fructosamine value must be less than or equal to 346 and secondly this test needs to have been recorded within the last 15 months. If both these criteria are met then the patient is selected into the numerator. If not, the patient is counted as a failure against the indicator.

Known concerns/issues

Managing different laboratory tests or reference ranges

The rule set provides an alternative value for fructosamine levels if HbA1C measurement is not available. If different reference ranges are used in the local laboratory then PCTs may need to make a manual adjustment to QMAS to reflect year end achievement.

Issues for assessment - There are no specific issues for assessment in relation to this indicator.

DM7: The percentage of patients with diabetes in whom the last HbA1c is 10 or less (or equivalent test/ reference range depending on local laboratory) in the previous 15 months²

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	97.9%	92.3%
2006 - 2007	97.8%	92.7%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks the most recent HbA1C recording against two criteria, both of which must be true in order for the patient to be selected into the denominator.
	<ul style="list-style-type: none"> • Firstly, the figure recorded for the HbA1C value must be less than or equal to 10 and • secondly this test needs to have been recorded within the last 15 months. If both these criteria are met then the patient is selected into the denominator. <p>If not, the next rule is applied.</p>
Rule 2	This rule checks the most recent fructosamine recording against two criteria, both of which must be true in order for the patient to be selected into the denominator. <ul style="list-style-type: none"> • Firstly, the figure recorded for the fructosamine value must be less than or equal to 400 and • secondly this test needs to have been recorded within the last 15 months. <p>If both these criteria are met then the patient is selected into the denominator. If not, the next rule is applied.</p>

² For 2009 -10 DM 7 (which has a HbA1C target of 10 or less) is replaced by 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 points: thresholds 40 – 90%)

Rule 3	This rule checks to see if the patient has registered with the practice in the last 9 months. If so then the patient can be exception reported. If not, then the next rule is applied.
Rule 4	This rule checks to see if a diabetes exception code has been entered into the record in the last 15 months. If so then the patient can be exception reported. If not, then the next rule is applied.
Rule 5	This rule checks to see if the earliest recording of the diabetes diagnosis is within the last 9 months. If so then the patient can be exception reported. If not, then the next rule is applied.
Rule 6	This rule checks to see if a code for maximal diabetes therapy has been entered into the record in the last 15 months. If so then the patient can be exception reported. All remaining records are selected into the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	<p>This rule checks the most recent HbA1C recording against two criteria, both of which must be true in order for the patient to be selected into the numerator.</p> <ul style="list-style-type: none"> • Firstly, the figure recorded for the HbA1C value must be less than or equal to 10 and • secondly this test needs to have been recorded within the last 15 months. <p>If both these criteria are met then the patient is selected into the numerator. If not, the next rule is applied.</p>
Rule 2	<p>This rule checks the most recent fructosamine recording against two criteria, both of which must be true in order for the patient to be selected into the numerator.</p> <ul style="list-style-type: none"> • Firstly, the figure recorded for the fructosamine value must be less than or equal to 400 and • secondly this test needs to have been recorded within the last 15 months. <p>If both these criteria are met then the patient is selected into the numerator. If not, the patient is counted as a failure against the indicator.</p>

Known concerns/issues

Managing different laboratory tests or reference ranges

- The rule set provides an alternative value for fructosamine levels if HbA1C measurement is not available. If different reference ranges are used in the local laboratory, then PCTs may need to make a manual adjustment to QMAS values, to reflect year end achievement.

Issues for assessment - There are no specific issues for assessment in relation to this indicator.

DM21: The percentage of patients with diabetes who have a record of retinal screening in the previous 15 months

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	93.5%	90.2%
2006 - 2007	91.0%	88.5%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see if the date of the latest retinal screening is within the last 15 months. If so the patient is selected into the denominator. If not, then the next rule is applied.
Rule 2	This rule checks to see if the patient has registered at the practice within the last 3 months. If so then the patient can be exception reported. If not, then the next rule is applied.
Rule 3	This rule checks to see if a diabetes exception code has been entered into the record in the last 15 months. If so then the patient can be exception reported. If not, then the next rule is applied.
Rule 4	This rule checks to see if a retinal screening exception reporting code has been added to the record in the last 15 months. If so then the patient can be exception reported. If not, then the next rule is applied.

Rule 5	This rule checks to see if the earliest date of the diabetes diagnosis is within the last 3 months. If so then the patient can be exception reported. All remaining records should be selected into the denominator.
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Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population.

Rule 1	This rule checks to see if the date of the latest retinal screening is within the last 15 months. If so the patient is selected into the numerator. If not, then the patient is counted as a failure against the indicator.
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Known concerns/issues - Diabetic retinopathy is one of the leading causes of blindness but it can be detected and managed through an effective retinal screening programme. Discussions with clinical QOF assessors suggest that this indicator requires a clear PCT policy in relation to their interpretation of this indicator which should be shared with contractors at the beginning of the QOF year. This should confirm the standard of screening which the PCT expects – the guidance states that this should usually be to national standards ie digital screening – and the circumstances in which a lesser standard is acceptable. This will be influenced by local circumstances and the availability of digital retinal screening.

Issues for assessment - Diabetic retinopathy is one of the leading causes of blindness but it can be detected and managed through an effective retinal screening programme. Discussions with clinical QOF assessors suggest that this indicator requires a clear PCT policy in relation to their interpretation of this indicator which should be shared with contractors at the beginning of the QOF year. This should confirm the standard of screening which the PCT expects – the guidance states that this should usually be to national standards ie digital screening – and the circumstances in which a lesser standard is acceptable. This will be influenced by local circumstances and the availability of digital retinal screening.

DM9: The percentage of patients with diabetes with a record of the presence or absence of peripheral pulses in the previous 15 months

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	95.0%	91.1%
2006 - 2007	93.8%	90.7%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see if the date of the latest recording of peripheral pulse codes is within the last 15 months. If so then the patient is selected into the denominator. If not, then the next rule is applied.
Rule 2	This rule checks to see if the patient has registered with the practice in the last 3 months. If so then the patient can be exception reported. If not, then the next rule is applied.
Rule 3	This rule checks to see if a diabetes exception reporting code has been entered into the record in the last 15 months. If so then the patient can be exception reported. If not, then the next rule is applied.
Rule 4	This rule checks to see if foot examination exception codes have been entered into the record in the last 15 months. If so then the patient can be exception reported. If not, then the next rule is applied.
Rule 5	This rule checks to see if the earliest date of the recording of the diabetes diagnosis is within the last 3 months. If so then the patient can be exception reported. All remaining records should be selected into the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks to see if the date of the latest recording of peripheral pulse codes is within the last 15 months. If so then the patient is selected into the numerator. If not, then the patient is counted as a failure against the indicator.
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Known concerns/issues - There are no known concerns/ queries in relation to this indicator.

Issues for assessment - There are no specific issues for assessment in relation to this indicator. Again assessors are reminded that each entry in support of this indicator should be linked to evidence of a consultation within the patient record or a letter from secondary care providing sufficient detail to demonstrate that the care described has been carried out. Good clinical practice is for an annual check for the patient; the 15 months cited in the indicator is to allow latitude for patients and the practice for measurement.

DM10: The percentage of patients with diabetes with a record of neuropathy testing in the previous 15 months

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	94.6%	90.8%
2006 - 2007	93.2%	90.2%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see if the latest recording of neuropathy testing is within the last 15 months. If so then the patient is selected into the denominator. If not, then the next rule is applied.
Rule 2	This rule checks to see if the patient has registered with the practice in the last 3 months. If so then the patient can be exception reported. If not, then the next rule is applied.
Rule 3	This rule checks to see if there is a diabetes exception reporting code entered into the record in the last 15 months. If so then the patient can be exception reported. If not, then the next rule is applied.
Rule 4	This rule checks to see if there is a foot examination exception reporting code entered into the record in the last 15 months. If so then the patient can be exception reported. If not, then the next rule is applied.

Rule 5	This rule checks to see if the date of the earliest recording of the diabetes diagnosis is within the last 3 months. If so then the patient can be exception reported. All remaining records should be selected into the denominator.
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Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks to see if the latest recording of neuropathy testing is within the last 15 months. If so then the patient is selected into the numerator. If not, then the patient is counted as a failure against the indicator.
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Known concerns/issues - There are no known concerns/ queries in relation to this indicator.

Issues for assessment - There are no specific issues for assessment in relation to this indicator. Again assessors are reminded that each entry in support of this indicator should be linked to evidence of a consultation within the patient record or a letter from secondary care providing sufficient detail to demonstrate that the care described has been carried out.

Clinical assessors may also wish to confirm that practices have the correct equipment eg tuning forks for vibration sense, two point discriminators) available to perform this check. Good clinical practice is for an annual check for the patient; the 15 months cited in the indicator is to allow latitude for patients and the practice for measurement.

DM11: The percentage of patients with diabetes who have a record of the blood pressure in the previous 15 months

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	99.9%	98.5%
2006 - 2007	99.8%	98.5%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks that the date of the latest blood pressure recording is within the last 15 months. If so then the patient is selected into the denominator. If not, then the next rule is applied.
Rule 2	This rule checks to see if there is a blood pressure exception reporting code has been entered into the record in the last 15 months. If so the patient can be exception reported. If not, then the next rule is applied.
Rule 3	This rule checks to see if the patient has registered with the practice in the last 3 months. If so then the patient can be exception reported. If not, then the next rule is applied.
Rule 4	This rule checks to see if a diabetes exception reporting code has been entered into the record in the last 15 months. If so then the patient can be exception reported. If not, then the next rule is applied.
Rule 5	This rule checks to see if the date of the earliest recording of the diabetes diagnosis is within the last 3 months. If it is then the patient can be exception reported. All remaining records should be entered into the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks that the date of the latest blood pressure recording is within the last 15 months. If so then the patient is selected into the numerator. If not, then the patient is counted as a failure against the indicator.
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Known concerns/issues - There are no known concerns/ queries in relation to this indicator.

Issues for assessment - A [QOF Assessor Validation report](#) has been commissioned to assist PCTs in the assessment of the monitoring and management of hypertension. Again assessors are reminded that each entry in support of this indicator should be linked to evidence of a consultation within the patient record or a letter from secondary care providing sufficient detail to demonstrate that the care described has been carried out. Good clinical practice is for an annual check for the patient; the 15 months cited in the indicator is to allow latitude for patients and the practice for measurement.

DM12: The percentage of patients with diabetes in whom the last blood pressure is 145/85 or less

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	99.6%	79.3%
2006 - 2007	99.3%	78.7%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	<p>This rule checks the most recent blood pressure recording against three criteria all of which must be true in order for the patient to be selected into the denominator.</p> <ul style="list-style-type: none"> • Firstly, the figure recorded for the systolic blood pressure must be less than or equal to 145 mm/Hg. • Secondly, the figure recorded for the diastolic blood pressure must be less than or equal to 85 mm/Hg and • finally this blood pressure needs to have been recorded within the last 15 months. <p>If all these criteria are met then the patient is selected into the denominator. If not the next rule is applied.</p>
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Rule 2	This rule checks to see if a blood pressure exception reporting code has been entered into the record in the last 15 months. If so then the patient can be exception reported. If not, then the next rule is applied.
Rule 3	This rule checks to see if the patient has registered at the practice in the last 3 months. If so the patient can be exception reported. If not, then the next rule is applied.
Rule 4	This rule checks to see if a diabetes exception reporting code has been entered into the record in the last 15 months. If so the patient can be exception reported. If not, then the next rule is applied.
Rule 5	This rule checks to see if the earliest recording of the diabetes diagnosis is within the last 9 months. If so then the patient can be exception reported. If not, then the next rule is applied.
Rule 6	This rule checks to see if a code for maximal blood pressure therapy has been entered into the record in the last 15 months. If so then the patient can be exception reported. All remaining records should be selected into the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for west Midlands register standards.

Rule 1	<p>This rule checks the most recent blood pressure recording against three criteria all of which must be true in order for the patient to be selected into the numerator.</p> <ul style="list-style-type: none"> • Firstly, the figure recorded for the systolic blood pressure must be less than or equal to 145 mm/Hg. • Secondly, the figure recorded for the diastolic blood pressure must be less than or equal to 85 mm/Hg and • finally this blood pressure needs to have been recorded within the last 15 months. <p>If all these criteria are met then the patient is selected into the numerator. If not the patient is counted as a failure against the indicator.</p>
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Known concerns/queries - There are no known concerns/ queries in relation to this indicator.

Issues for assessment - There are no specific issues for assessment in relation to this indicator. A [QOF Assessor Validation report](#) has been commissioned to assist PCTs in the assessment of the monitoring and management of hypertension.

Assessing maximal blood pressure therapy can be challenging and should be carried out by a clinical assessor. Discussions with clinical assessors suggest that the number of patients excepted for this reason should be low and each decision should be supported by free text detailing the rationale for this decision in the patient record.

DM13: 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)

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	89.5%	86.5%
2006 - 2007	87.6%	85.6%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see if there is a code for proteinuria within the patient record. If there is then the patient is rejected from the denominator. If not, then the next rule is applied.
Rule 2	This rule checks to see if the date of the latest micro-albuminuria test is within the last 15 months. If so then the patient is selected into the denominator. If not, then the next rule is applied.
Rule 3	This rule checks to see if the patient has registered with the practice in the last 3 months. If so then the patient can be exception reported. If not, then the next rule is applied.
Rule 4	This rule checks to see if a diabetes exception reporting code has been added to the record in the last 15 months. If so then the patient can be exception reported. If not, then the next rule is applied.
Rule 5	This rule checks to see if the date of the earliest recording of the diabetes diagnosis is within the last 3 months. If so then the patient can be exception reported. All remaining records should be selected into the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks to see if the date of the latest micro-albuminuria test is within the last 15 months. If so then the patient is selected into the numerator. If not, then the patient is counted as a failure against the indicator.
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Known concerns/issues -

Do patients with proteinuria need to be exception reported?

Patients with a record of an accepted proteinuria code are identified by the first rule of the denominator rule set and are removed from the denominator at that point. They do not need an additional exception reporting code added to their record.

Issues for assessment - There are no specific issues for assessment in relation to this indicator. Assessors may wish to discuss with practices the approach they take to assessing micro-albuminuria, including the appropriate maintenance of near patient testing equipment and/or the encouragement of laboratory based testing. Good clinical practice is for an annual check for the patient; the 15 months cited in the indicator is to allow latitude for patients and the practice for measurement.

DM22: 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

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	99.5%	96.8%
2006 - 2007	99.3%	96.6%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see that either the date of the latest creatinine test or the date of the latest eGFR test is within the last 15 months. If so then the patient is selected into the denominator. If not, then the next rule is applied.
Rule 2	This rule checks to see if the patient has registered with the practice in the last 3 months. If so then the patient can be exception reported. If not, then the next rule is applied.
Rule 3	This rule checks to see if a diabetes exception reporting code has been added to the record in the last 15 months. If so, the patient can be exception reported. If not, then the next rule is applied.
Rule 4	This rule checks to see if the earliest recording of the diabetes diagnosis is within the last 3 months. If so then the patient can be exception reported. All remaining records should be selected into the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks to see that either the date of the latest creatinine test or the date of the latest eGFR test is within the last 15 months. If so then the patient is selected into the numerator. If not, then the patient is counted as a failure against the indicator.
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Known concerns/issues - There are no known concerns/ queries in relation to this indicator.

Issues for assessment - There are no specific issues for assessment in relation to this indicator. Good clinical practice is for an annual check for the patient; the 15 months cited in the indicator is to allow latitude for patients and the practice for measurement.

DM15: The percentage of patients with diabetes with a diagnosis of proteinuria or micro-albuminuria who are treated with ACE inhibitors (or A2 antagonists)

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	95.9%	89.1%
2006 - 2007	94.4%	89.0%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see if the patient has either proteinuria or micro-albuminuria. If neither condition is present then the patient is rejected from the denominator. If either condition is recorded then the next rule is applied.
Rule 2	This rule checks to see whether either an ACE or an A2 antagonist has been prescribed within the last 6 months. If so then the patient is selected into the denominator. If not, then the next rule is applied.
Rule 3	This rule checks to see if the patient has registered with the practice in the last 3 months. If so the patient can be exception reported. If not, then the next rule is applied.
Rule 4	This rule checks to see if a diabetes exception reporting code has been added to the record in the last 15 months. If so then the patient can be exception reported. If not, then the next rule is applied.
Rule 5	This rule checks to see if the date of the earliest recording of the diabetes diagnosis is within the last 3 months. If so then the patient can be exception reported. If not, then the next rule is applied.
Rule 6	This rule checks to see if there is a code for either an expiring or persisting ACE inhibitor contraindication entered into the record. If neither code is present then the patient is selected into the denominator. If not, then the next rule is applied.
Rule 7	This rule checks to see that there is no code for a persisting ACE contraindication and that the code for an expiring ACE contraindication has been entered within the last 15 months. If this code has been entered before this timeframe then the patient is selected into the denominator.

Rule 8	This rule checks to see if there is a code for either an expiring or persisting A2 antagonist contraindication entered into the record. If neither code is present then the patient is selected into the denominator. If not, then the next rule is applied.
Rule 9	This rule checks to see that there is no code for a persisting A2 antagonist contraindication and that the code for an expiring A2 antagonist contraindication has been entered within the last 15 months. If this code has been entered before this timeframe then the patient is selected into the denominator. All remaining records are rejected from the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks to see whether either an ACE or an A2 antagonist has been prescribed within the last 6 months. If so then the patient is selected into the numerator. If not, then the patient is counted as a failure against the indicator.
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Known concerns/issues

Exception reporting for contraindications

Again, practices and assessors are reminded that, where appropriate, a persisting or expiring contraindication code for both ACE inhibitors or a A2 antagonist should be added to the patient record. If these codes are not present and the patient is not prescribed either medication then they will be selected into the denominator and count as a failure against the indicator.

Issues for assessment - There are no specific issues for assessment in relation to this indicator.

DM16: The percentage of patients with diabetes who have a record of total cholesterol in the previous 15 months

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	99.5%	96.1%
2006 - 2007	99.3%	96.2%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see that the date of the latest cholesterol test is within the last 15 months. If so then the patient is selected into the denominator. If not, then the next rule is applied.
Rule 2	This rule checks to see if the patient has registered with the practice in the last 3 months. If so then the patient can be exception reported. If not, then the next rule is applied.
Rule 3	This rule checks to see a diabetes exception reporting code has been entered into the record in the last 15 months. If so then the patient can be exception reported. If not, then the next rule is applied.
Rule 4	This rule checks to see if the earliest recording of the diabetes diagnosis is within the last 3 months. If so then the patient can be exception reported. All remaining records should be selected into the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks to see that the date of the latest cholesterol test is within the last 15 months. If so then the patient is selected into the numerator. If not, then the patient is counted as a failure against the indicator.
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Known concerns/issues - There are no known concerns/ queries in relation to this indicator.

Issues for assessment - There are no specific issues for assessment in relation to this indicator. Good clinical practice is for an annual check for the patient; the 15 months cited in the indicator is to allow latitude for patients and the practice for measurement.

DM17: The percentage of patients with diabetes whose last measured total cholesterol within the previous 15 months is 5mmol/l or less

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	99.2%	83.2%
2006 - 2007	98.8%	83.1%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks the most recent cholesterol level recording against two criteria both of which must be true in order for the patient to be selected into the denominator. Firstly, the figure recorded for the cholesterol level must be less than or equal to 5mmol/l. Secondly, the date of this test should be within the last 15 months. If both of these criteria are met then the patient is selected into the denominator. If not, then the next rule is applied.
Rule 2	This rule checks to see if the patient has recently registered at the practice ie within the last 9 months. If this is the case then the patient can be exception reported from the denominator. If not, then the next rule is applied.
Rule 3	This rule checks to see if a diabetes exception reporting code has been added to the record in the last 15 months. If so then the patient can be exception reported from the denominator. If not, the next rule is applied.
Rule 4	This rule checks to see if the date of the earliest recording of the diabetes diagnosis is within the last 9 months. If so then the patient can be exception reported from the denominator. If not then the next rule is applied.

Rule 5	This rule checks to see if there is either a persisting cholesterol testing exception code in the record or an expiring cholesterol testing exception code added to the record in the last 15 months. If so then the patient can be exception reported. All remaining records are selected into the denominator.
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Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population.

Rule 1	This rule checks the most recent cholesterol level recording against two criteria both of which must be true in order for the patient to be selected into the numerator. Firstly, the figure recorded for the cholesterol level must be less than or equal to 5mmol/l. Secondly, the date of this test should be within the last 15 months. If both of these criteria are met then the patient is selected into the numerator. If not, then the patient is counted as a failure against the indicator.
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Known concerns/issues - There are no known concerns/ queries in relation to this indicator.

Issues for assessment - There are no specific issues for assessment in relation to this indicator. Good clinical practice is for an annual check for the patient; the 15 months cited in the indicator is to allow latitude for patients and the practice for measurement.

DM18: The percentage of patients with diabetes who have had influenza immunization in the preceding 1 September to 31 March

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	98.3%	90.4%
2006 - 2007	97.9%	90.7%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see that the date of the latest flu vaccination is on or after the 1st September and on or before the 31st March. If so the patient is selected into the denominator. If not, then the next rule is applied.
Rule 2	This rule checks to see if the patient has registered with the practice in the last 3 months. If so the patient can be exception reported. If not, then the next rule is applied.
Rule 3	This rule checks to see if a diabetes exception reporting code has been entered into the record in the last 15 months. If so then the patient can be exception reported. If not, then the next rule is applied.
Rule 4	This rule checks to see if the date of the earliest recording of the diabetes diagnosis is within the last 3 months. If so then the patient is exception reported. If not, then the next rule is applied.
Rule 5	This rule checks to see if there is a persisting flu vaccination contraindication entered into the record. If there is then the patient is exception reported. If not, then the next rule is applied.
Rule 6	This rule checks to see if there is an expiring flu vaccination contraindication entered into the record in the last 15 months. If so the patient is exception reported. All remaining records are selected into the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks to see that the date of the latest flu vaccination is on or after the 1st September and on or before the 31st March. If so the patient is selected into the numerator. If not, then the patient is counted as a failure against the indicator.
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Known concerns/issues - There are no known concerns/ queries in relation to this indicator.

Issues for assessment - There are no specific issues for assessment in relation to this indicator.

Chronic obstructive pulmonary disease (COPD)

Indicator	Points	Payment Stages
Records		
COPD1: The practice can produce a register of patients with COPD	3	
Initial Diagnosis		
COPD12: The percentage of all patients with COPD diagnosed after 1st April 2008 in whom the diagnosis has been confirmed by post bronchodilator spirometry	5	40 - 80%
Ongoing Management		
COPD10: The percentage of patients with COPD with a record of FeV1 in the previous 15 months	7	40 - 70%
COPD11: The percentage of patients with COPD receiving inhaled treatment in whom there is a record that inhaler technique has been checked in the previous 15 months	7	40 - 90%
COPD8: The percentage of patients with COPD who have had influenza immunization in the preceding 1 September to 31 March	6	40 - 85%

Prevalence

Year	Sum of Register Counts	Unadjusted Prevalence
2007 - 2008	799,772	1.5%
2006 - 2007	765,806	1.4%
2005 -2006	732,418	1.4%
2004 -2005	716,508	1.4%

Indicator Detail

COPD1: The practice can produce a register of patients with COPD

Key Points to note

Patients with asthma and COPD should be included on both registers.

COPD12: The percentage of all patients with COPD diagnosed after 1st April 2008 in whom the diagnosis has been confirmed by post bronchodilator spirometry

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks that the earliest date of the recording of the COPD diagnosis is after the 1st April 2008. This is because this was the date on which this indicator was introduced and it applies to new diagnoses only. Patients diagnosed with COPD prior to this date are excluded from the denominator. Where the patient was diagnosed after 1st April 2008 the next rule is applied.
Rule 2	This rule checks that post-bronchodilator spirometry has been performed at some point between the 3 months before and the 12 months after the diagnosis was recorded. If so then the patient is selected into the denominator. If not, then the next rule is applied.
Rule 3	This rule checks to see if the patient has registered with the practice in the last 3 months. If this is the case then the patient is exception reported. If not, then the next rule is applied.
Rule 4	This rule checks to see if a COPD exception reporting code has been entered into the record in the last 15 months. If this is the case then the patient is exception reported. If not, then the net rule is applied.
Rule 5	This rule checks to see if a spirometry exception code has been added to the record in the last 15 months. If so then the patient is exception reported. If not, then the next rule is applied.

Rule 6	This rule checks to see if the earliest recording of the COPD diagnosis is within the last 3 months. If this is the case then the patient is exception reported. All remaining records are selected into the denominator.
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Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population.

Rule 1	This rule checks that post-bronchodilator spirometry has been performed at some point between the 3 months before and the 12 months after the diagnosis was recorded. If so then the patient is selected into the numerator. If not, then the patient is counted as a failure against the indicator.
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Known concerns/issues

This indicator applies to new diagnoses after 1st April 2008 only. This change was introduced to bring the QOF in line with NICE guidance which did not recommend the routine use of reversibility testing.

Issues for assessment - There are no specific issues for assessment in relation to this indicator.

COPD10: The percentage of patients with COPD with a record of FeV1 in the previous 15 months

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	95.4%	82.0%
2006 - 2007	93.0%	80.7%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks that the date of the latest recording of an FeV1 is within the last 15 months. If this is the case then the patient is selected into the denominator. If not, then the next rule is applied.
Rule 2	This rule checks to see if the patient has registered with the practice in the last 3 months. If this is the case then the patient is exception reported. If not, then the next rule is applied.
Rule 3	This rule checks to see if a COPD exception reporting code has been entered into the record in the last 15 months. If this is the case then the patient is exception reported. If not, then the next rule is applied.
Rule 4	This rule checks to see if the earliest recording of the COPD diagnosis is within the last 3 months. If this is the case then the patient is exception reported. All remaining records are selected into the denominator.

Numerator

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Rule 1	This rule checks that the date of the latest recording of an FeV1 is within the last 15 months. If this is the case then the patient is selected into the numerator. If not, then the patient is counted as a failure against the indicator.
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Known concerns/queries

Exception reporting

The spirometry exception codes are not used in the rule set supporting this indicator. Therefore to exception report a patient from this indicator the general COPD exception codes should be used.

Issues for assessment - There are no specific issues for assessment in relation to this indicator. Good clinical practice is for an annual check for the patient; the 15 months cited in the indicator is to allow latitude for patients and the practice for measurement.

COPD11: The percentage of patients with COPD receiving inhaled treatment in whom there is a record that inhaler technique has been checked in the previous 15 months³

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	95.4%	91.2%
2006 - 2007	93.5%	90.4%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see that the patient has received a prescription for inhaled therapy in the last 6 months. If this is not the case then the patient is excluded from the denominator as they are not eligible for the care described. If this is the case then the next rule is applied.
Rule 2	This rule checks to see if the date of the latest assessment of inhaler technique is within the last 15 months. If this is the case then the patient is selected into the denominator. If not, then the next rule is applied.
Rule 3	This rule checks to see if the patient has registered with the practice in the last 3 months. If this is the case then the patient is exception reported. If not, then the next rule is applied.
Rule 4	This rule checks to see if a COPD exception reporting code has been entered into the record in the last 15 months. If this is the case then the patient is exception reported. If not, then the next rule is applied.
Rule 5	This rule checks to see if the earliest recording of the COPD diagnosis is within the last 3 months. If this is the case then the patient is exception reported. All remaining records should be selected in the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

³ For 2009 -10, COPD 11 is replaced by 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.

Rule 1	This rule checks to see if the date of the latest assessment of inhaler technique is within the last 15 months. If this is the case then the patient is selected into the numerator. If not, then the patient is counted as a failure against the indicator.
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Known concerns/queries - There are no known concerns/ queries in relation to this indicator.

Issues for assessment - Assessors should check that any codes entered in support of this indicator can be linked to either evidence of a consultation within the patient record or a clinical letter which states that this activity has been performed. Inhaler techniques can only be checked face to face, not by telephone. Good clinical practice is for an annual check for the patient; the 15 months cited in the indicator is to allow latitude for patients and the practice for assessment.

COPD8: The percentage of patients with COPD who have had influenza immunization in the preceding 1 September to 31 March

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	98.7%	91.8%
2006 - 2007	98.4%	92.0%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see that the date of the latest flu vaccination is on or after the 1st September and on or before the 31st March. If so the patient is selected into the denominator. If not, then the next rule is applied.
Rule 2	This rule checks to see if the patient has registered with the practice in the last 3 months. If so the patient can be exception reported. If not, then the next rule is applied.

Rule 3	This rule checks to see if a COPD exception reporting code has been entered into the record in the last 15 months. If so then the patient can be exception reported. If not, then the next rule is applied.
Rule 4	This rule checks to see if the date of the earliest recording of the COPD diagnosis is within the last 3 months. If so then the patient is exception reported. If not, then the next rule is applied.
Rule 5	This rule checks to see if there is a persisting flu vaccination contraindication entered into the record. If there is then the patient is exception reported. If not, then the next rule is applied.
Rule 6	This rule checks to see if there is an expiring flu vaccination contraindication entered into the record in the last 15 months. If so the patient is exception reported. All remaining records are selected into the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks to see that the date of the latest flu vaccination is on or after the 1st September and on or before the 31st March. If so the patient is selected into the numerator. If not, then the patient is counted as a failure against the indicator.
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Known concerns/queries - There are no known concerns/ queries in relation to this indicator.

Issues for assessment - There are no specific issues for assessment in relation to this indicator.

Epilepsy

Indicator	Points	Payment Stages
Records		
EPILEPSY5: The practice can produce a register of patients aged 18 and over receiving drug treatment for epilepsy	1	
Ongoing Management		
EPILEPSY6: 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%
EPILEPSY7: 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%
EPILEPSY8: 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%

Prevalence

Year	Sum of Register Counts	Unadjusted Prevalence
2007 - 2008	324,130	0.6%
2006 - 2007	321,411	0.6%
2005 -2006	323,654	0.6%
2004 -2005	312,604	0.6%

Indicator Detail

EPILEPSY5: The practice can produce a register of patients aged 18 and over receiving drug treatment for epilepsy

Key Points to note

From 1st April 2008 the age range for this indicator changed from 17 years and over to 18 years and over.

To be included on this register patients need to have both a diagnosis of epilepsy and to have received a prescription for drug treatment in the last 6 months of the QOF year.

EPILEPSY6: 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

Achievement

This was a new indicator from 1 April 2008 and as such no achievement is available.

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see if the latest recording of seizure frequency is within the last 15 months. If it is then the patient is selected into the denominator. If not then the next rule is applied.
Rule 2	This rule checks to see if the patient has registered with the practice in the last 3 months. If this is the case then the patient is exception reported. If not, then the next rule is applied.

Rule 3	This rule checks to see if an epilepsy exception reporting code has been entered into the record in the last 15 months. If so the patient is exception reported from the denominator. If not, then the next rule is applied.
Rule 4	This rule checks to see if the earliest recording of the epilepsy diagnosis is within the last 3 months. If this is the case then the patient is exception reported. All remaining records should be selected into the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks to see if the latest recording of seizure frequency is within the last 15 months. If it is then the patient is selected into the numerator. If not, then the patient is counted as a failure against the indicator.
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Known concerns/queries - There are no known concerns/ queries in relation to this indicator.

Issues for assessment - There are no specific issues for assessment in relation to this indicator.

EPILEPSY7: 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

Achievement

This was a new indicator from 1 April 2008 and as such no achievement is available.

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see if the date of the latest recording of an epilepsy medication review is within the last 15 months. If this is the case then the patient is selected into the denominator. If not, then the next rule is applied.
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Rule 2	This rule checks to see if the patient has registered with the practice in the last 3 months. If this is the case then the patient is exception reported. If not, then the next rule is applied.
Rule 3	This rule checks to see if an epilepsy exception recording code has been entered into the record in the last 15 months. If so then the patient is exception reported. If not, then the next rule is applied.
Rule 4	This rule checks to see if the date of the earliest recording of an epilepsy diagnosis is within the last 3 months. If so then the patient is exception reported. All remaining records should be selected into the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks to see if the date of the latest recording of an epilepsy medication review is within the last 15 months. If this is the case then the patient is selected into the numerator. If not, then the patient is counted as a failure against the indicator.
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Known concerns/queries - There are no known concerns/ queries in relation to this indicator.

Issues for assessment - There are no specific issues for assessment in relation to this indicator.

EPILEPSY8: 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

Achievement

This was a new indicator in 2008 and as such no achievement information is available.

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see if the latest record of the patient being seizure free for 12 months has been entered in the last 15 months. If this is the case then the patient is selected into the denominator. If not, then the next rule is applied.
Rule 2	This rule checks to see if the patient has registered with the practice in the last 3 months. If this is the case then the patient is exception reported. If not, then the next rule is applied.
Rule 3	This rule checks to see if an epilepsy exception reporting code has been entered into the record in the last 15 months. If this is the case then the patient is exception reported. If not, then the next rule is applied.
Rule 4	This rule checks to see if there is a record of the patient being on maximal anti-convulsant therapy in the last 15 months. If this is the case then the patient is exception reported. If not, then the next rule is applied.
Rule 5	This rule checks to see if the earliest recording of the epilepsy diagnosis is within the last 3 months. If this is the case then the patient is exception reported. All remaining records should be selected into the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population.

Rule 1	This rule checks to see if the latest record of the patient being seizure free for 12 months has been entered in the last 15 months. If this is the case then the patient is selected into the numerator. If not, then the patient is counted as a failure against the indicator.
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Known concerns/queries - There are no known concerns/ queries in relation to this indicator.

Issues for assessment - In some patients with epilepsy, reaching a seizure free state can be difficult to achieve. To acknowledge this the upper threshold for maximal payment is lower than the majority of indicators at 70%.

Assessors are advised that it is good practice to restrict 'Maximal tolerated therapy' codes to patients who are taking a multiple of anti-convulsants and are under the care of an epilepsy specialist.

Hypothyroid

Indicator	Points	Payment Stages
Records		
THYROID1: The practice can produce a register of patients with hypothyroidism	1	
Ongoing Management		
THYROID2: The percentage of patients with hypothyroidism with thyroid function tests recorded in the previous 15 months	6	40 - 90%

Prevalence

Year	Sum of Register Counts	Unadjusted Prevalence
2007 - 2008	1,461,912	2.7%
2006 - 2007	1,367,117	2.5%
2005 -2006	1,263,409	2.4%
2004 -2005	1,153,640	2.2%

Indicator Detail

THYROID1: The practice can produce a register of patients with hypothyroidism

Key Points to note

To be included on this register patient’s require both a diagnosis of hypothyroidism and a record of a hypothyroid treatment code within the last 6 months of the QOF year.

Assessors should be aware that it is possible to be on hypothyroid treatment and not to have a diagnosis of hypothyroidism. They should discuss with practices their approach to register construction and validation and how they ensure that diagnoses are not entered in error. See Annex for West Midlands register standards.

THYROID2: The percentage of patients with hypothyroidism with thyroid function tests recorded in the previous 15 months

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	99.5%	96.1%
2006 - 2007	99.5%	96.3%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see if there is a record of thyroid functioning tests having been undertaken in the last 15 months. If there is then the patient is selected into the denominator. If not the next rule is applied.
Rule 2	This rule checks to see if the patient has registered with the practice in the last 3 months. If they have then the patient can be exception reported. If not then the next rule is applied.
Rule 3	This rule checks to see if a hypothyroid exception reporting code has been entered into the record in the last 15 months. If this is present then the patient is excepted from the denominator. If not the next rule is applied.
Rule 4	This rule checks to see if the diagnosis of hypothyroidism is recent ie within the last 3 months. If this is the case then the patient can be excepted from the denominator. All remaining patients are entered into the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks to see if there is a record of thyroid function tests having been performed in the last 15 months. If there is then the patient is entered into the numerator. If not then the patient is a failure against the indicator.
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Known concerns/queries - There are no known concerns/ queries in relation to this indicator.

Issues for assessment - There are no specific issues for assessment in relation to this indicator. Good clinical practice is for an annual check for the patient; the 15 months cited in the indicator is to allow latitude for patients and the practice for measurement.

Cancer

Indicator	Points	Payment Stages
Records		
CANCER1: 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		
CANCER3: 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%

Prevalence

Year	Sum of Register Counts	Unadjusted Prevalence
2007 - 2008	585,797	1.1%
2006 - 2007	488,576	0.9%
2005 -2006	384,344	0.7%
2004 -2005	270,033	0.5%

Indicator Detail

CANCER1: 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'

Key Points to note

Some anomalies in the supporting rule sets have been identified when practices have migrated from v2 to v3 systems. PCTs are asked to continue highlighting these as they are identified. Assessors may also wish to discuss with practices their approach to the construction of this register and particularly how they ensure that all diagnoses made in secondary care are transferred to the primary care record. See Annex for West Midlands register standards.

CANCER3: 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

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	92.9%	93.7%
2006 - 2007	93.3%	94.4%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see if the date of the latest, first or new diagnosis of cancer is within the last 18 months. If the diagnosis is outside of this timeframe than the patient is excluded from the denominator. If not, then the next rule is applied.
Rule 2	This rule checks to see if the date of the latest, first or new cancer diagnosis is within the last 6 months and if there is a record of a cancer care review having been performed. If there is no record of a review having been performed then the patient is rejected from the denominator as there is time for the review to be performed after the end of the QOF year. If not then the next rule is applied.
Rule 3	This rule checks to see if a cancer care review has been recorded within the last 12 months. If the review has been recorded outside of this timeframe then the patient is rejected from the denominator as the activity would have been rewarded in a previous QOF year. If not, then the next rule is applied.

Rule 4	This rule checks to see if a cancer care review has been recorded as having taken place within 6 months of the date of the cancer diagnosis. If this is the case then the patient is selected into the denominator. If not, then the next rule is applied.
Rule 5	This rule checks to see if the patient has registered with the practice in the last 3 months. If this is the case then the patient is exception reported. If not, then the next rule is applied.
Rule 6	This rule checks to see if a cancer exception reporting code has been entered into the record in the last 15 months. If this is the case then the patient is exception reported. If not, then the next rule is applied.
Rule 7	This rule checks to see if the date of the cancer diagnosis is within the last 3 months. If this is the case then the patient is exception reported. All remaining records should be selected into the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks to see if a cancer care review has been recorded as having taken place within 6 months of the date of the cancer diagnosis. If this is the case then the patient is selected into the numerator. If not, then the patient is counted as a failure against the indicator.
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Known concerns/queries - The rule set supporting this indicator has been constructed to ensure that firstly practices are rewarded once for each review they perform and secondly that they are not penalised if the review period crosses the end of the QOF year. To do this the rule set calculates those patients eligible for a review in the previous 18 months. Patients are then removed from the denominator if

- they have had a review performed in the previous QOF year as the practice would have been rewarded for this review at the end of the previous QOF year and if
- they have not had a review performed and the final date for this to occur is after the end of the QOF year in question.

Issues for assessment - PCTs should ensure that all elements of a review are performed as detailed in the QOF Guidance. Cancer reviews should be performed by a suitably qualified person. Assessors may wish to discuss with practices how they ensure that all staff performing cancer reviews are suitably qualified for the role.

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	

Prevalence

The prevalence adjustment for the palliative care register is 1, irrespective of actual register size. This means that the payment per point is only adjusted for total list size rather than by the number of patients on the register as well as list size.

Indicator Detail

PC3: The practice has a complete register available of all patients in need of palliative care/ support irrespective of age

Key Points to note

This indicator changed from 1st April 2008 to include patients of all ages. The register is generated using a mixture of diagnostic and administrative codes. This register should include patients in need of palliative support irrespective of their underlying diagnosis and should therefore include patients with conditions other than cancer.

As a way of assessing the completeness of this register, assessors may wish to discuss with practices the number of registered patients who have died in the last 12 months, who did not die from an acute illness, that were on the palliative care register.

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

Narrative description of the rule set

This is a self reported Boolean (yes/ no) indicator, so there is no supporting rule set.

Known concerns/ queries -

Practices should be able to demonstrate that they cover the aims of the case review meetings which are:

- Ensure that each patient has a management plan as defined by the practice team and that decisions are acted upon by the most appropriate member of the team
- Ensure that the management plan includes preference for place of care
- Ensure that the support needs of carers are discussed and addressed wherever reasonably possible.

The practice should submit written evidence to the PCO describing the system for initiating and recording meetings.

This indicator stipulates that the practice should have regular multidisciplinary case review meetings ie every three months. If these do not occur, then the requirements for the indicator are not met.

Issues for assessment - There are no specific issues for assessment in relation to this indicator.

Mental Health

Indicator	Points	Payment Stages
Records		
MH8: The practice can produce a register of people with schizophrenia, bipolar affective disorder and other psychoses	4	
Ongoing Management		
MH9: 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%
MH4: The percentage of patients on lithium therapy with a recording of serum creatinine and TSH in the preceding 15 months	1	40-90%
MH5: 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 careers 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%

Prevalence

Year	Sum of Register Counts	Unadjusted Prevalence
2007 - 2008	394,395	0.7%
2006 - 2007	380,383	0.7%
2005 -2006	317,122	0.6%
2004 -2005	290,926	0.6%

Indicator Detail

MH8: The practice can produce a register of people with schizophrenia, bipolar affective disorder and other psychoses

Key Points to note

From the 1st April 2006 the process for generating this register changed from the use of administrative codes to diagnostic codes. There are now two criteria for entry to the mental health register. Either a patient has a relevant diagnosis or they have received a prescription for lithium therapy within the last six months of the QOF year.

At present it is not possible to remove a patient from the mental health register if they have a qualifying diagnosis in their record. Patients who would no longer benefit from the care described in the mental health indicators as they have recovered may be exception reported against them. Unfortunately it is not possible to give national guidance as to what constitutes recovery as this is a retrospective diagnosis which will vary between individuals. Assessors may wish to discuss with practices how they reach this determination and how they ensure that they are not merely identifying patients who have become 'lost to follow up' who may require more assertive management.

The Read code hierarchy supporting the Mental Health register is complex. Practices are advised to review patient records to ensure that the original diagnosis is correct, especially where they have migrated records across different clinical terminologies.

MH9: 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 patients has been offered routine health promotion and prevention advice appropriate to their age, gender and health status

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	96.4%	92.6%
2006 - 2007	94.4%	91.5%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule seeks to identify those patients who are on the mental health register only because they are in receipt of a lithium prescription and who do not have a diagnosis of schizophrenia, bipolar affective disorder or other psychoses. These patients should be excluded from the denominator. The next rule is applied to the records of those patients with a diagnosis of schizophrenia, bipolar affective disorder or other psychoses.
Rule 2	This rule checks to see if the date of the latest recording of a mental health review is within the last 15 months. If this is the case then the patient is selected into the denominator. If not, then the next rule is applied.
Rule 3	This rule checks to see if the patient has registered with the practice in the last 3 months. If this is the case then the patient is exception reported. If not, then the next rule is applied.
Rule 4	This rule checks to see if a mental health exception reporting code has been entered into the record in the last 15 months. If this is the case then the patient is exception reported. If not, then the next rule is applied.
Rule 5	This rule checks to see if the earliest date of the recording of a mental health diagnosis is within the last 3 months. If this is the case then the patient is exception reported. All remaining records should be selected into the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population.

Rule 1	This rule checks to see if the date of the latest recording of a mental health review is within the last 15 months. If this is the case then the patient is selected into the numerator. If not, then the patient is counted as a failure against the indicator.
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Known concerns/ queries

What is sufficient for a practice to demonstrate they have carried out the clinical review required for this indicator?

The exact composition of each review will vary with the patient and their medication. However

page 73 of Quality and Outcomes Framework guidance for GMS contract 2008/09' suggests that this should normally include:

- Issues relating to alcohol or drug use
- Smoking and blood pressure
- Cholesterol checks where clinically appropriate
- BMI
- An assessment of the risk of diabetes from olanzepine and risperidone
- Cervical screening

It is also an opportunity to perform a medication review

Issues for assessment - There are a significant number of points associated with this indicator and it also seeks to address a potentially significant health inequality in relation to the differences in physical health between those with a psychiatric condition and the wider community. PCTs are advised to undertake an audit of patient records to ensure that all relevant activities are being performed, and to ensure that where practices are claiming for a review undertaken in secondary care that the necessary attention has been paid to the physical elements of this review.

Good practice would indicate that this review would be undertaken in a face to face consultation. If this is not the case then there should be evidence in the patient record that all relevant activities have been performed in close proximity to the date of the recording of the review code. This may include reviewing relevant letters from secondary care and others involved in the patient's care as well as recent consultations. Again good practice would dictate that this should be undertaken by a clinician.

Good clinical practice is for an annual check for the patient; the 15 months cited in the indicator is to allow latitude for patients and the practice for measurement.

MH4: The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 15 months

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	91.3%	97.1%
2006 - 2007	90.8%	96.8%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see which patients have received a prescription for lithium within the last 6 months. If they have then the next rule is applied to the patient record. If there is no record of a prescription then the patient is excluded from the denominator
Rule 2	This rule checks to see if there is a record of creatinine and thyroid function tests having been performed in the last 15 months. If this is the case then the patient is selected into the denominator. If not, then the next rule is applied.
Rule 3	This rule checks to see if the patient has registered with the practice in the last 3 months. If this is the case then the patient is exception reported. If not, then the next rule is applied.
Rule 4	This rule checks to see if a mental health exception reporting code has been added to the record in the last 15 months. If this is the case then the patient is exception reported. If not, then the next rule is applied.
Rule 5	This rule checks to see if the date of the earliest lithium prescription is within the last 3 months. If this is the case then the patient is exception reported. All remaining records should be selected into the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks to see if there is a record of creatinine and thyroid function tests having been performed in the last 15 months. If this is the case then the patient is selected into the numerator. If not, then the patient is counted as a failure against the indicator.
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Known concerns/ queries -

What should practices and assessors do if the practice has no patients on lithium therapy?

Where a practice has no patients on lithium therapy then they are not entitled to the points described in this or the subsequent indicator as they are not delivering this care to their patients.

Issues for assessment - There are no specific issues for assessment in relation to this indicator.

Good clinical practice is for an annual check for the patient; the 15 months cited in the indicator is to allow latitude for patients and the practice for measurement.

MH5: The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the previous 6 months

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	83.9%	91.2%
2006 - 2007	83.1%	90.5%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see which patients have received a prescription for lithium within the last 6 months. If they have then the next rule is applied to the patient record. If there is no record of a prescription then the patient is excluded from the denominator.
Rule 2	This rule checks the most recent serum lithium recording against three criteria all of which must be true in order for the patient to be selected into the denominator. Firstly, the date of the latest serum lithium test must be within the last 6 months. Secondly, the figure recorded for the serum lithium level must be less than or equal to 1 and thirdly, greater than or equal to 0.4. If all these criteria are met then the patient is selected into the denominator. If not the next rule is applied.
Rule 3	This rule checks firstly to see if the date of latest recording of a therapeutic serum lithium code is the same as the date of the latest recording of the serum lithium code. Secondly it checks to see that the date of the latest recording of a therapeutic serum lithium code is within the last 6 months. If both these criteria are true then the patient is selected into the denominator. If not, then the next rule is applied.
Rule 4	This rule checks to see if the patient has registered with the practice in the last 3 months. If this is the case then the patient is exception reported. If not, then the next rule is applied.
Rule 5	This rule checks to see if a mental health exception reporting code has been added to the record in the last 15 months. If this is the case then the patient is exception reported from the denominator. If not, then the next rule is applied.

Rule 6	This rule checks to see if the earliest recording of a lithium prescription is within the last 9 months. If this is the case then the patient is exception reported as practice's have 9 months in which to achieve therapeutic indicators in new patients. All remaining records should be selected into the denominator.
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Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks the most recent serum lithium recording against three criteria all of which must be true in order for the patient to be selected into the numerator. Firstly, the date of the latest serum lithium test must be within the last 6 months. Secondly, the figure recorded for the serum lithium level must be less than or equal to 1 and thirdly, greater than or equal to 0.4. If all these criteria are met then the patient is selected into the numerator. If not the next rule is applied.
Rule 2	This rule checks firstly to see if the date of latest recording of a therapeutic serum lithium code is the same as the date of the latest recording of the serum lithium code. Secondly it checks to see that the date of the latest recording of a therapeutic serum lithium code is within the last 6 months. If both these criteria are true then the patient is selected into the numerator. If not, then the patient is counted as a failure against the indicator.

Known concerns/ queries - There are no known concerns in relation to this indicator.

Issues for assessment - There are no specific issues for assessment in relation to this indicator. Lithium levels can be critical which is why good clinical practice is for a six monthly record.

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

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	98.0%	83.9%
2006 - 2007	94.0%	75.7%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule seeks to identify those patients who are on the mental health register only because they are in receipt of a lithium prescription and who do not have a diagnosis of schizophrenia, bipolar affective disorder or other psychoses. These patients should be excluded from the denominator. The next rule is applied to the records of those patients with a diagnosis of schizophrenia, bipolar affective disorder or other psychoses.
Rule 2	This rule checks to see that the record contains a code for a mental health care plan having been completed and that the latest recording of this code is after the date of the qualifying mental health diagnosis. If this is the case then the patient is selected into the denominator. If not, then the next rule is applied.
Rule 3	This rule checks to see if the patient has registered with the practice in the last 3 months. If this is the case then the patient is exception reported. If not, then the next rule is applied.
Rule 4	This rule checks to see if a mental health exception reporting code has been entered into the patient record in the last 15 months. If this is the case then the patient is exception reported. If not, then the next rule is applied.
Rule 5	This rule checks to see if the earliest recording of the mental health diagnosis is within the last 3 months. If this is the case then the patient is exception reported. All remaining records should be selected into the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks to see that the record contains a code for a mental health care plan having been completed and that the latest recording of this code is after the date of the qualifying mental health diagnosis. If this is the case then the patient is selected into the numerator. If not, then the patient is counted as a failure against the indicator.
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Known concerns/ queries

How frequently should a care plan be updated?

Care plans should be reviewed on an annual basis and signed and dated. Where a patient is under CPA then the current care plan should be included in the GP patient record.

What should a care plan contain?

Care plans should contain all the elements described on page 75 of the [‘Quality and Outcomes Framework guidance for GMS contract 2008/09’](#)

Issues for assessment - There are no specific issues for assessment in relation to this indicator.

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

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	65.7%	88.8%
2006 - 2007	60.1%	90.9%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule seeks to identify those patients who are on the mental health register only because they are in receipt of a lithium prescription and who do not have a diagnosis of schizophrenia, bipolar affective disorder or other psychoses. These patients should be excluded from the denominator. The next rule is applied to the records of those patients with a diagnosis of schizophrenia, bipolar affective disorder or other psychoses.
Rule 2	This rule seeks to identify patients who did not attend a mental health annual review in the last 15 months. If there is no record of the patient having missed an appointment then the record is excluded from the denominator. If there is a record of a DNA then the next rule is applied.
Rule 3	This rule checks to see whether any follow up activity has been recorded within two weeks of the patient not attending their review appointment. Where this has happened then the patient is selected in to the denominator. If not, then the next rule is applied.
Rule 4	This rule checks to see if the DNA date is within the last 2 weeks. If this is the case then the patient is rejected from the denominator as the practice still has time in which to complete the follow up activity and the patient record will be re-examined in the next QOF year. If this is not the case then the next rule is applied.
Rule 5	This rule checks to see if the patient has registered with the practice in the last 3 months. If this is the case then the patient is exception reported. If not, then the next rule is applied.
Rule 6	This rule checks to see if a mental health exception reporting code has been entered into the record in the last 15 months. If this is the case then the patient is exception reported. If not, then the next rule is applied.
Rule 7	This rule checks to see if the earliest recording of the qualifying mental health diagnosis is within the last 3 months. If this is the case then the patient is exception reported. All remaining records should be selected into the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks to see whether any follow up activity has been recorded within two weeks of the patient not attending their review appointment. Where this has happened then the patient is selected in to the numerator. If not, then the patient is counted as a failure against the indicator.
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Known concerns/ queries

If a practice dose not have any patients who DNA their annual review are they still eligible for the points associated with this indicator?

No. This indicator is specifically designed to reward practices who chase up non-attenders as there is evidence to suggest that non-attendance at health care appointments can signify deterioration in the patient's mental state.

What follow-up activities are sufficient to achieve the points associated with this indicator?

Page 77 of 'Quality and Outcomes Framework guidance for GMS contract 2008/09' states that this indicator requires proactive intervention on the part of the practice. This may be through telephone contact or a visit, or if the patient is in contact with secondary care a discussion with their key worker. The practice should provide evidence as to how this contact has been made. It would not normally be sufficient to send a reminder letter to meet the terms of this indicator.

Issues for assessment

PCTs should seek evidence as to the type of contact made with patients who DNA their annual review.

Asthma

Indicator	Points	Payment Stages
Records		
ASTHMA1: 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		
ASTHMA8: 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		
ASTHMA3: 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%
ASTHMA6: The percentage of patients with asthma who have had an asthma review in the previous 15 months	20	40-70%

Prevalence

Year	Sum of Register Counts	Unadjusted Prevalence
2007 - 2008	3,105,212	5.7%
2006 - 2007	3,099,526	5.8%
2005 -2006	3,101,275	5.8%
2004 -2005	3,073,401	5.8%

Indicator Detail

ASTHMA1: 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

Key Points to note

To be included on the asthma register patients need to fulfil both eligibility criteria ie they need to have a diagnosis of asthma and they need to have a record of a prescription for asthma related drugs in the current QOF year.

ASTHMA8: The percentage of patients aged eight and over diagnosed as having asthma from 1 April 2006 with measures of variability and reversibility

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	95.4%	87.8%
2006 - 2007	93.6%	88.8%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see that the patient is aged over eight years old. If the patient is less than eight then they are rejected from the denominator. If not, then the next rule is applied.
Rule 2	This rule checks to see that earliest date of the asthma diagnosis is after the 1st April 2006. Patients diagnosed prior to this are rejected from the denominator. If the patient was diagnosed after this date then the next rule is applied.

Rule 3	This rule checks that the measure of reversibility and/ or variability has been performed. The acceptable timeframe for this to be performed is any time after the date of the asthma diagnosis and up to three months before the diagnosis was recorded. If this is the case then the patient is selected into the denominator. If not, then the next rule is applied.
Rule 4	This rule checks to see whether a peak flow recording has been recorded. The acceptable timeframe for this to be performed is any time after the date of the asthma diagnosis and up to three months before the diagnosis was recorded. If this is the case then the patient is selected into the denominator. If not, then the next rule is applied.
Rule 5	This rule checks to see if the patient has registered with the practice in the last 3 months. If this is the case then the patient is exception reported. If not, then the next rule is applied.
Rule 6	This rule checks to see if an asthma exception reporting code has been entered into the record in the last 15 months. If this is the case then the patient is exception reported. If not, then the next rule is applied.
Rule 7	This rule checks to see if the earliest recording of the asthma diagnosis is within the last 3 months. If this is the case then the patient is exception reported. All remaining records should be selected into the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population.

Rule 1	This rule checks that the measure of reversibility and/ or variability has been performed. The acceptable timeframe for this to be performed is any time after the date of the asthma diagnosis and up to three months before the diagnosis was recorded. If this is the case then the patient is selected into the numerator. If not, then the next rule is applied.
Rule 2	This rule checks to see whether a peak flow recording has been recorded. The acceptable timeframe for this to be performed is any time after the date of the asthma diagnosis and up to three months before the diagnosis was recorded. If this is the case then the patient is selected into the numerator. If not, then the patient is counted as a failure against the indicator.

Known concerns/ queries -

What advice can be offered to practices as to the management of patients diagnosed with asthma prior to the age of 8 years?

Where a child has a long-standing and accurate diagnosis of asthma then the practice may not consider it appropriate to stop current medication to undertake spirometry. In these circumstances, or where the diagnosis is uncertain, practices are reminded of the advice given on page 80 of the 'Quality and Outcomes Framework guidance for GMS contract 2008/09' in relation to the importance of accurate assessment. Serial peak flow measurements may be more appropriate. Where a practice decides against confirming a diagnosis and seeks to exception report the patient from this indicator this decision should be supported by clear free text providing the supporting rationale.

Issues for assessment - There are no specific issues for assessment in relation to this indicator.

ASTHMA3: 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

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	98.1%	88.9%
2006 - 2007	97.5%	88.3%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see if the patient is aged less than 14 years old. If this is the case they are rejected from the denominator. If not then the next rule is applied.
Rule 2	This rule checks to see if the patient is more than 19 years old. If this is the case then they are rejected from the denominator. If not then the next rule is applied.

Rule 3	This rule checks to see if there is a recording of smoking status in the last 15 months. If this is the case then the patient is selected into the denominator. If not then the next rule is applied.
Rule 4	This rule checks to see if the patient has registered with the practice in the last 3 months. If this is the case then they are exception reported. If not, then the next rule is applied.
Rule 5	This rule checks to see if an asthma exception reporting code has been entered into the record in the last 15 months. If this is the case then the patient is exception reported. If not then the next rule is applied.
Rule 6	This rule checks to see if the earliest recording of the asthma diagnosis is within the last 3 months. If so then the patient is exception reported. All remaining records should be selected into the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks to see if there is a recording of smoking status in the last 15 months. If this is the case then the patient is selected into the numerator. If not then the patient is counted as a failure against the indicator.
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Known concerns/ queries - There are no known concerns/ queries in relation to this indicator.

Issues for assessment - There are no specific issues for assessment in relation to this indicator. Good clinical practice at these ages is for an annual question for the patient; the 15 months cited in the indicator is to allow latitude for patients and the practice for recording.

ASTHMA6: The percentage of patients with asthma who have had an asthma review in the previous 15 months

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	98.7%	79.3%
2006 - 2007	97.5%	78.9%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see if there is a record of an asthma review within the last 15 months. If there is then the patient is selected into the denominator. If not then the next rule is applied.
Rule 2	This rule checks to see if the patient has registered with the practice in the last 3 months. If this is the case then the patient is exception reported. If not then the next rule is applied.
Rule 3	This rule checks to see if an asthma exception reporting code has been entered into the record in the last 15 months. If this is the case then the patient is exception reported. If not then the next rule is applied.
Rule 4	This rule checks to see if the earliest recording of an asthma diagnosis is within the last 3 months. If this is the case then the patient is exception reported. All remaining records should be selected into the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks to see if there is a record of an asthma review within the last 15 months. If there is then the patient is selected into the numerator. If not then the patient is counted as a failure against the indicator.
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Known concerns/ queries - Queries have been received in relation to the acceptability of telephone reviews in order to fulfil this indicator. This was considered by both the negotiating parties and the expert panel who felt that there was insufficient evidence to support recommending this. An assessment of inhaler technique is an important element of this review and cannot be performed in the absence of a face-to-face consultation. PCTs are advised to give clear guidance to their practices as to their policy with regard to this indicator.

Issues for assessment - PCTs should review a number of clinical records to ensure that all elements of an asthma review, as described in [Quality and Outcomes Framework guidance](#) for GMS contract 2008/09, have been completed. Good clinical practice is for an annual check for the patient; the 15 months cited in the indicator is to allow latitude for patients and the practice for measurement.

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%

Prevalence

Year	Sum of Register Counts	Unadjusted Prevalence
2007 - 2008	220,246	0.4%
2006 - 2007	212,794	0.4%

Indicator Detail

DEM1: The practice can produce a register of patients diagnosed with dementia

Key Points to note

There are no key points to note in relation to this register.

DEM2: The percentage of patients diagnosed with dementia whose care has been reviewed in the previous 15 months

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	96.8%	80.5%
2006 - 2007	96.6%	81.5%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks that the dementia review has been performed in the last 15 months and that it has been performed after the date of the dementia diagnosis. If this is the case then the patient is selected into the denominator. If not then the next rule is applied.
Rule 2	This rule checks to see if the patient has registered with the practice in the last 3 months. If they have then this is an acceptable reason for the patient to be excepted from the denominator. If not then the next rule is applied.
Rule 3	This rule checks to see if a dementia exception reporting code has been entered into the record in the last 15 months. If this is present then the patient is excepted from the denominator. If not then the next rule is applied.
Rule 4	This rule checks to see if the diagnosis of dementia is recent ie within the last 3 months. If this is the case then the patient can be excepted from the denominator. If not then the patient is included in the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks that the dementia review has taken place in the last 15 months and that it has taken place after the date of the dementia diagnosis. If this has happened then the patient is selected into the numerator. If not they are counted as a failure against the indicator.
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Known concerns/ queries - Queries have been received as to what practices should be doing to demonstrate that they have carried out this review. The elements of the review are described in Quality and Outcomes Framework guidance for GMS contract 2008/09 and include:

- An appropriate physical and mental health review for the patient
- 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
- If applicable, the impact of caring on the carer
- Communication and co-ordination arrangements with secondary care (if applicable)

Given the heterozygous nature of people with this condition it is difficult to be prescriptive as to the physical and mental health conditions which should be covered in a review. This will need to be individualised to the patient. However the guidance does highlight some areas for consideration e.g. behavioural changes due to physical symptoms, depression and changes in the manifestation of the condition.

Issues for assessment - PCTs are advised to review a number of records to ensure that the elements of a review described have been completed. Assessors may wish to review exception reporting in relation to this indicator to ensure that patients are not being excepted just because they are resident in a Care home. It is good practice that these patients are not excluded from care which they could be expected to benefit from. Good clinical practice is for an annual check for the patient; the 15 months cited in the indicator is to allow latitude for patients and the practice for measurement.

Depression

Indicator	Points	Payment Stages
Diagnosis and Initial Management		
DEP1: The percentage of patients on the diabetes 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%

Prevalence

Prevalence figures have not been published for these indicators.

Indicator Detail

DEP1:: The percentage of patients on the diabetes and/or CHD register for whom case finding for depression has been undertaken on one occasion during the previous 15 months using two standard screening questions

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	91.4%	87.9%
2006 - 2007	79.7%	81.0%

Identifying the target population

All indicators have a target population ie the group of patients to whom the care described should be given. For most indicators this is defined in the disease specific register. However the depression indicators are different in that there is no register indicator. Therefore instruction as to how to identify the target population is given in the rule set. For this indicator the target population is patients on either the diabetes and/ or CHD register. The number of patients meeting these criteria is used to calculate the prevalence adjustment for Depression1.

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see if there is a record of case finding for depression having been performed in the last 15 months. If this is the case then the patient is selected into the denominator. If not then the next rule is applied.
Rule 2	This rule checks to see if the patient has been diagnosed with depression in the last 15 months. If this is the case then they do not require case finding and are rejected from the denominator, Of not then the next rule is applied.
Rule 3	The rule checks to see if the patient has registered with the practice in the last 3 months. If this is the case then they are excepted from the denominator. If not then the next rule is applied.
Rule 4	This rule checks to see if a depression exception reporting code has been entered into the record in the last 15 months. If this is the case then the patient is excepted from the denominator. If not then the next rule is applied.
Rule 5	This rule checks to see if the earliest recording of either CHD or diabetes is within the last 3 months. It should be noted that the diagnosis date of interest is the earliest of either of these two qualifying conditions. If this is the case then the patient can be excepted from the denominator. All remaining records should be selected into the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks to see if there is a record of case finding for depression having been performed in the last 15 months. If this is the case then the patient is selected into the numerator. If not then the patient is counted as a failure against the indicator.
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Known concerns/ queries -

Can the screening questions be posted to patients?

Page 89 of [Quality and Outcomes Framework guidance](#) for GMS contract 2008/09 states that this screening should take place as part of a consultation and the questions should not be posted to patients.

Issues for assessment - There are no specific issues in relation to the assessment of this indicator. Good clinical practice is for an annual check for the patient; the 15 months cited in the indicator is to allow latitude for patients and the practice for measurement.

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

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	90.3%	91.3%
2006 - 2007	81.2%	85.1%

Identifying the target population

As with Depression 1 the 'target population' or register for this indicator is described within the rule set. In this case the target population is all patients with an active diagnosis of depression ie within the clinical record there is a recording of a diagnostic code for depression which is not followed by a depression resolved code. It is this figure which is used to calculate the prevalence adjustment. Assessors may wish to discuss with practices their approach to the creation and validation of this target population and the process for ensuring that cases are reviewed regularly and resolved when appropriate.

As will be described below, the first rule within the denominator rule set targets those with a diagnosis within the preceding 1 April to 31 March.

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see if the patient has been diagnosed with depression within the last 12 months. Diagnoses made outside of this timeframe are excluded from the denominator. Where the diagnosis has been made in the last 12 months then the next rule is applied.
Rule 2	This rule checks to see if the depression severity assessment has been performed. The acceptable timeframe for doing this is within one month of the depression diagnosis. If this is the case then the patient is selected into the denominator. If not then the next rule is applied.
Rule 3	This rule checks to see if the patient has registered with the practice in the last 3 months. If this is the case then they are exception reported. If not then the next rule is applied.
Rule 4	This rule checks to see if a depression exception reporting code has been entered into the record in the last 15 months. If this is the case then the patient is excepted from the denominator. If not then the next rule is applied.
Rule 5	This rule checks to see if the diagnosis of depression has been made in the last 3 months. If this is the case then the patient is exception reported. All remaining records should be selected into the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks to see if the depression severity assessment has been performed. The acceptable timeframe for doing this is within one month of the depression diagnosis. If this is the case then the patient is selected into the numerator. If not then the patient is counted as a failure against the indicator.
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Known concerns/ queries -

Does this indicator run from 1st April every year or is it cumulative?

This indicator runs from 1st April every year in relation to those patients who should have an assessment of severity. The underlying 'register' or target population is cumulative in that it will include all patients with an active diagnosis of depression irrespective of when it was made.

How is 'at the onset of treatment' defined?

For the purpose of QOF measurement at the outset of treatment' is defined as within one month of the qualifying diagnosis.

Issues for assessment - In order to validate the underlying 'register' PCTs are advised to discuss with practices how they are ensuring that only patients with an active diagnosis are included and the process for adding a depression resolved code when patients improve. The severity scores derived from the assessment tools map across to the stepped care management options described in NICE guidance. PCTs may wish to consider auditing records to see if severity scores map to levels of antidepressant prescribing.

Chronic Kidney Disease

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 and angiotensin receptor blocker (ARB) (unless a contraindication or side effects are recorded)	4	40-80%

Prevalence

Year	Sum of Register Counts	Unadjusted Prevalence
2007 - 2008	1,589,353	2.9%
2006 - 2007	1,279,246	2.4%

Indicator Detail

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)

Key Points to note

Patients are entered onto the register once they have been given a clinical diagnosis of Chronic Kidney Disease (CKD). A minimum of two eGFR recordings of less than 60mL/min/1.73m² in the previous 3 months are required to make this diagnosis. Patients should remain on the register once this diagnosis has been made even if there is an improvement in eGFR results following active management. Page 92 of 'Quality and Outcomes Framework guidance for GMS contract 2008/09' highlights that an estimated 5% of the population have CKD stage 3 – 5.

Patients should not be excluded from this diagnosis on the basis of age.

CKD2: The percentage of patients on the CKD register whose notes have a record of blood pressure in the previous 15 months

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	99.4%	97.8%
2006 - 2007	99.0%	98.1%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see if there is a blood pressure recording within the last 15 months. If this is the case then the patient is selected into the denominator. If not then the next rule is applied.
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Rule 2	This rule checks to see if a blood pressure recording exception reporting code has been entered into the record in the last 15 months. If this is the case then the patient is excepted from the denominator. If not then the next rule is applied.
Rule 3	This rule checks to see if the patient has registered with the practice in the last 3 months. If this is the case then the patient is exception reported. If not then the next rule is applied.
Rule 4	This rule checks to see if a CKD exception reporting code has been entered into the record in the last 15 months. If this is the case then the patient is exception reported. If not then the next rule is applied.
Rule 5	This rule checks to see if the earliest date of a CKD diagnosis is within the last 3 months. If this is the case then the patient is exception reported. All remaining records should be selected into the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks to see if there is a blood pressure recording within the last 15 months. If this is the case then the patient is selected into the numerator. If not then the patient is counted as a failure against the indicator.
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Known concerns/ queries - There are no known concerns/ queries in relation to this indicator.

Issues for assessment - There are no specific issues for assessment in relation to this indicator, although a QOF Assessor Validation report has been commissioned to assist PCTs in the assessment of blood pressure control. Again assessors are reminded that each code entered in support of this indicator should be linked to evidence of a consultation within the patient record. Good clinical practice is for an annual check for the patient; the 15 months cited in the indicator is to allow latitude for patients and the practice for measurement..

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

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	94.3%	74.0%
2006 - 2007	96.9%	86.9%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	<p>This rule checks the most recent blood pressure recording against three criteria all of which must be true in order for the patient to be selected into the denominator.</p> <ul style="list-style-type: none"> • Firstly, the figure recorded for the systolic blood pressure must be less than or equal to 140 mm/Hg. • Secondly, the figure recorded for the diastolic blood pressure must be less than or equal to 85 mm/Hg and • finally this blood pressure needs to have been recorded within the last 15 months. <p>If all these criteria are met then the patient is selected into the denominator. If not the next rule is applied.</p>
Rule 2	<p>This rule checks to see if a blood pressure exception reporting code has been entered into the record in the last 15 months. If so then the patient can be exception reported. If not, then the next rule is applied.</p>
Rule 3	<p>This rule checks to see if the patient has registered at the practice in the last 3 months. If so the patient can be exception reported. If not, then the next rule is applied.</p>
Rule 4	<p>This rule checks to see if a CKD exception reporting code has been entered into the record in the last 15 months. If so the patient can be exception reported. If not, then the next rule is applied.</p>
Rule 5	<p>This rule checks to see if the earliest recording of the CKD diagnosis is within the last 9 months. If so then the patient can be exception reported. If not, then the next rule is applied.</p>

Rule 6	This rule checks to see if a code for maximal blood pressure therapy has been entered into the record in the last 15 months. If so then the patient can be exception reported. All remaining records should be selected into the denominator.
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Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	<p>This rule checks the most recent blood pressure recording against three criteria all of which must be true in order for the patient to be selected into the numerator.</p> <ul style="list-style-type: none"> • Firstly, the figure recorded for the systolic blood pressure must be less than or equal to 140 mm/Hg. • Secondly, the figure recorded for the diastolic blood pressure must be less than or equal to 85 mm/Hg and • finally this blood pressure needs to have been recorded within the last 15 months. <p>If all these criteria are met then the patient is selected into the numerator. If not, then the patient will not be counted in achievement against the indicator.</p>
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Known concerns/ queries - There are no known concerns/ queries in relation to this indicator.

Issues for assessment - There are no specific issues for assessment in relation to this indicator but a QOF Assessor Validation report has been commissioned to assist PCTs in the assessment of blood pressure control. Good clinical practice is for an annual check for the patient; the 15 months cited in the indicator is to allow latitude for patients and the practice for measurement.

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)

Achievement

This was a new indicator in 2008 and therefore no results are available.

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see that the patient has an active diagnosis of hypertension. If they do then the next rule is applied. If they don't then they are rejected from the denominator.
Rule 2	This rule checks to see if the patient has proteinuria. If the record does not contain a code for proteinuria then the patient is rejected from the denominator. If they do then the next rule is applied.
Rule 3	This rule checks to see if the patient has been given a prescription for either an ACE or an ARB in the last 6 months. If this is the case then they are selected into the denominator. If not then the next rule is applied.
Rule 4	This rule checks to see if the patient has registered with the practice in the last 3 months. If this is the case then the patient is exception reported. If not then the next rule is applied.
Rule 5	This rule checks to see if a CKD exception reporting code has been entered into the patient record in the last 15 months. If this is the case then the patient is excepted from the denominator. If not then the next rule is applied.
Rule 6	This rule checks to see if the earliest recording of the CKD diagnosis is within the last 3 months. If this is the case then the patient is excepted from the denominator. If not then the next rule is applied.
Rule 7	This rule checks to see if there is a record of an expiring and a persisting contraindication to ACE drugs. If neither code is present then the patient is selected into the denominator. If not the next rule is applied.

Rule 8	This rule checks to see that there is no record of a persisting contraindication to ACE therapy and to see if the last recording of an expiring contraindication to ACE therapy was made in the last 15 months. Where the record of an expiring contraindication was made out with of this timeframe then the patient is selected into the denominator. If not the next rule is applied.
Rule 9	This rule checks to see if there is a record of either a persisting or expiring contraindication to ARB therapy. If neither code is present then the patient is selected into the denominator. If not then the next rule is applied.
Rule 10	This rule checks to see that there is no record of a persisting contraindication to ARB therapy and to see if the last recording of an expiring contraindication code was made in the last 15 months. Where the recording of an expiring contraindication was made out with of this time frame then the patient is selected into the denominator. All remaining records are rejected from the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks to see if the patient has been given a prescription for either ACE or ARB in the last 6 months. If this is the case then they are selected into the numerator. If not then the patient is counted as a failure against the indicator.
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Known concerns/ queries - There are no known concerns/ queries in relation to this indicator.

Issues for assessment - There are no specific issues for assessment in relation to this indicator.

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	15	40-90%

Prevalence

Year	Sum of Register Counts	Unadjusted Prevalence
2007 - 2008	701,157	1.3%
2006 - 2007	692,054	1.3%

Indicator Detail

AF1: The practice can produce a register of patients with atrial fibrillation

Key Points to note

This register is comprised of all patients with atrial fibrillation. Some clinical systems record atrial flutter as a synonym for atrial fibrillation despite these being different conditions. The rule set therefore includes both.

AF4: The percentage of patients with atrial fibrillation diagnosed after 1 April 2008 with ECG or specialist confirmed diagnosis

Achievement

This is a new indicator in 2008 and as such no achievement data is available.

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see if the diagnosis of atrial fibrillation was made after 1st April 2008. If this is the case then the next rule is applied. If the diagnosis was made prior to this date then the patient is excluded from the denominator.
Rule 2	This rule checks to see that the diagnosis has been confirmed by either ECG or specialist opinion. The acceptable timeframe for this is from three months before the recording of the diagnosis and up to three months after the recording. If this is the case then the patient is selected into the denominator. If not then the next rule is applied.
Rule 3	This rule checks to see if the patient has registered with the practice in the last 3 months. If this is the case then they are exception reported. If not then the next rule is applied.
Rule 4	This rule checks to see if an atrial fibrillation exception reporting code has been entered into the record in the last 15 months. If this is the case then the patient is exception reported. If not then the next rule is applied.
Rule 5	This rule checks to see if the earliest recording of an atrial fibrillation diagnosis is within the last 3 months. If this is the case then the patient is exception reported. All remaining records should be selected into the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks to see that the diagnosis has been confirmed by either ECG or specialist opinion. The acceptable timeframe for this is from three months before the recording of the diagnosis and up to three months after the recording. If this is the case then the patient is selected into the numerator. If not then the patient is counted as a failure against the indicator.
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Known concerns/ queries - There are no known concerns/ queries in relation to this indicator.

Issues for assessment - PCTs and practices should note that the time frame for completing the ECG has changed from 1st April 2008 to between 3 months before and after the recording of the diagnosis.

AF3: The percentage of patients with atrial fibrillation who are currently treated with anti-coagulation drug therapy or an anti-platelet therapy

Achievement

Year	Percentage of points achieved	Underlying percentage achievement
2007 - 2008	98.8%	93.7%
2006 - 2007	98.6%	94.3%

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see if there is a record of the patient having either anti-coagulation or anti-platelet therapy in the last 6 months. If this is the case then the patient is selected into the denominator. If not then the next rule is applied.
Rule 2	This rule checks to see if the patient has registered with the practice in the last 3 months. If this is the case then they are exception reported from the denominator. If not then the next rule is applied.
Rule 3	This rule checks to see if an atrial fibrillation exception reporting code has been entered into the record in the last 15 months. If this is the case then the patient is exception reported. If not then the next rule is applied.
Rule 4	This rule checks to see if the earliest recording of an atrial fibrillation diagnosis is within the last 3 months. If this is the case then the patient is exception reported. If not then the next rule is applied.

Rule 5	This rule checks to see if there are any expiring or persistent salicylate contraindication codes in the record. If neither code is present then the patient is selected into the denominator. If not then the next rule is applied.
Rule 6	This rule checks to see that there is no persisting salicylate contraindication code and to see if any expiring salicylate contraindication code has been entered into the record in the last 15 months. If the expiring contraindication code was added before this time then the patient is selected into the denominator. If not then the next rule is applied.
Rule 7	This rule checks to see if there are any expiring or persistent warfarin exception codes in the record. If neither code is present then the patient is selected into the denominator. If not then the next rule is applied.
Rule 8	This rule checks to see that there is no persisting contraindication code for warfarin and that any expiring code for warfarin contraindications has been entered into the record in the last 15 months. If the expiring contraindication code was added before this time then the patient is selected into the denominator. If not then the next rule is applied.
Rule 9	This rule checks to see if there are any expiring or persistent clopidogrel contraindication codes in the record. If neither code is present then the patient is selected into the denominator. If not then the next rule is applied.
Rule 10	This rule checks to see that there is no persisting contraindication to clopidogrel and that any expiring contraindication code has been entered into the record in the last 15 months. If the expiring contraindication code was added before this time then the patient is selected into the denominator. If not then the next rule is applied.
Rule 11	This rule checks to see if there are any expiring or persistent dipyridamole contraindication codes in the record. If neither code is present then the patient is selected into the denominator. If not then the next rule is applied.
Rule 12	This rule checks to see that there is no persisting contraindication to dipyridamole and that any expiring contraindication code has been entered into the record in the last 15 months. If the expiring contraindication code was added before this time then the patient is selected into the denominator. All remaining records are rejected from the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population.

Rule 1	This rule checks to see if there is a record of the patient having been given a prescription for either anti-coagulation or anti-platelet therapy in the last 6 months. If this is the case then the patient is selected into the numerator. If not then the patient is counted as a failure against the indicator.
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**Known concerns/ queries -
Exception reporting for contraindications**

Practices are reminded that contraindication codes should be added to the patient record for each relevant drug. Failure to do so and failure to prescribe anti-coagulation or anti-platelet therapy will result in the patient being included in the denominator and counting as a failure against the indicator.

Exception reporting for paroxysmal AF

Any decision to exception report patients with paroxysmal AF in relation to this indicator should be made on a case by case basis and supported by free-text within the patient record as appropriate. Good practice would suggest that this decision is made as a result of a clinical consultation and is entered by a clinician.

Issues for assessment

There are no specific issues for assessment in relation to this indicator.

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	

Prevalence

Year	Sum of Register Counts	Unadjusted Prevalence
2007 - 2008	4,129,304	7.6%
2006 - 2007	3,978,713	7.4%

Indicator Detail

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

Key Points to note

This register will identify patients aged 16 and over who have had a BMI performed within the practice in the previous 15 months and found to have a BMI greater than or equal to 30. Therefore the resulting 'prevalence' rate reported by the Information Centre on an annual basis are more akin to incidence in a consulting population and therefore will be lower than population estimates as they will be limited by the number of patients who have had a BMI performed. This indicator also only applies to adults so does not provide an estimate of childhood obesity.

Learning Disabilities

Indicator	Points	Payment Stages
Records		
LD1: The practice can produce a register of patients with learning disabilities	4	

Prevalence

Year	Sum of Register Counts	Unadjusted Prevalence
2007 - 2008	144,909	0.3%
2006 - 2007	139,321	0.3%

Indicator Detail

LD1: The practice can produce a register of patients with learning disabilities

Key Points to note

This register is generated using a combination of diagnostic and administrative codes. PCTs should discuss with practices the strategy they employed to ensure that all relevant patients have been identified. This may require additional condition specific searches.

Smoking

Indicator	Points	Payment Stages
Ongoing Management		
Smoking3: 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 and other psychoses whose notes record smoking status in the previous 15 months	33	40-90%
Smoking4: 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 and 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	35	40-90%

Prevalence

The prevalence calculation for this indicator set is the sum of all the eligible disease registers listed.

Indicator Detail

Smoking3: 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 and other psychoses whose notes record smoking status in the previous 15 months

Achievement

This was a new indicator in 2008 and therefore there are no achievement figures available.

Identifying the target population

This indicator set does not have a register indicator. Therefore the target population is described within the rule set. In this case the target population is patients with one or more of the listed diagnoses.

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to identify those patients with one or more of the qualifying diagnoses listed in the indicator. Where one or more of these conditions are present then the next rule is applied.
Rule 2	This rule checks to see if there is a record of current smoking status in the last 15 months. If this is the case then the patient is selected into the denominator. If not then the next rule is applied.
Rule 3	This rule checks the patient record against four criteria. Firstly, is the patient aged over 25 years? Secondly, is there a record of them never having smoked? Thirdly, is the date of the recording of the never smoked status after the date of the diagnosis of the first qualifying disease and fourthly was the never smoked status entered into the patient record after they were 25 years old? If all these are true then the patient is selected into the denominator. If not then the next rule is applied.
Rule 4	This rule checks to see if the patient is less than 25 years old and that there is a record of them never having smoked in the last 12 months. If this is the case then the patient is selected into the denominator. If not then the next rule is applied.
Rule 5	This rule checks to see if there is a record of the patient being an ex-smoker and that this record has been made in the last 15 months. If this is the case then the patient is selected into the denominator. If not then the next rule is applied.
Rule 6	This rule checks to see if the patient has been recorded as being an ex-smoker for three consecutive years. It also checks that the patient has not subsequently been recorded as being a smoker. If this is the case then the patient is selected into the denominator. If not then the next rule is applied.
Rule 7	This rule checks to see if the patient has registered with the practice in the last 3 months. If this is the case then they are exception reported. If not then the next rule is applied.

Rule 8	This rule checks to see if a smoking exception reporting code has been entered into the record in the last 15 months. If this is the case then the patient is exception reported. If not then the next rule is applied.
Rule 9	This rule checks to see if the earliest recording of the diagnosis of the earliest qualifying condition listed in the indicator is within the last 3 months. If this is the case then the patient is exception reported. All remaining records should be selected into the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population. See Annex for West Midlands register standards.

Rule 1	This rule checks to see if there is a record of current smoking status in the last 15 months. If this is the case then the patient is selected into the numerator. If not then the next rule is applied.
Rule 2	This rule checks the patient record against four criteria. Firstly, is the patient aged over 25 years? Secondly, is there a record of them never having smoked? Thirdly, is the date of the recording of the never smoked status after the date of the diagnosis of the first qualifying disease and fourthly was the never smoked status entered into the patient record after they were 25 years old? If all these are true then the patient is selected into the numerator. If not then the next rule is applied.
Rule 3	This rule checks to see if the patient is less than 25 years old and that there is a record of them never having smoked in the last 12 months. If this is the case then the patient is selected into the numerator. If not then the next rule is applied.
Rule 4	This rule checks to see if there is a record of the patient being an ex-smoker and that this record has been made in the last 15 months. If this is the case then the patient is selected into the numerator. If not then the next rule is applied.
Rule 5	This rule checks to see if the patient has been recorded as being an ex-smoker for three consecutive years. It also checks that the patient has not subsequently been recorded as being a smoker. If this is the case then the patient is selected into the numerator. All remaining records should be counted as failures against the indicator.

Known concerns/ queries - The rule sets for this indicator have undergone significant changes for 2008. Practices should note that any smoking status needs to be recorded after the date of the diagnosis of the date of the earliest diagnosis of a qualifying chronic disease.

Where patients are less than 25 years old at the point of diagnosis and have never smoked this will need to be recorded on an annual basis until the patient reaches the age of 25 years.

Ex smokers will need to have this recorded on an annual basis for three consecutive years. Once this has been achieved then patients do not need to be questioned again. However practices should note that if a smoking code is entered at a later date, even if it is another ex-smoker code, then the previous consecutive three year recording is over-ridden for QOF purposes and the ex-smoking status will need to be recorded for a further three consecutive years for the patient to continue to be counted against the indicator.

Recording patients as non-smokers

The new construction of the ruleset requires that patients are categorised as either current smokers, ex-smokers or those who have never smoked. Those who have been recorded as 'non-smokers' or 'current non-smokers' are by definition either ex-smokers or they have never smoked. However to make this distinction would require access to the patient record. One of the code clusters within the ruleset includes the codes for 'non-smoker' but that these codes are not then being captured in the numerator of the indicator. NHS PCC has raised this anomaly with Connecting for Health.

Given that this cannot be corrected until after year end PCTs are advised to suggest that practices recode those currently recorded as 'non-smokers' as either 'ex-smokers' or 'never smoked'. This should ensure that they appear in both the numerator and the denominator

Issues for assessment - There are no specific issues for assessment in relation to this indicator.

Smoking4: 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 and 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

Achievement

This was a new indicator in 2008 and therefore there are no achievement figures available.

Narrative description of the rule set

This section should be read in conjunction with the rule set and provides a narrative as to the purpose of each rule within the denominator and numerator.

Denominator

Rule 1	This rule checks to see if the patient is recorded as currently being a smoker. If this is not the case then they are rejected from the denominator. If they are then the next rule is applied.
Rule 2	This rule checks to see that there is a record of smoking cessation advice having been given in the last 15 months. If this is the case then the patient is selected into the denominator. If not then the next rule is applied.
Rule 3	This rule checks to see if the patient has registered with the practice in the last 3 months. If this is the case then the patient is exception reported. If not then the next rule is applied.
Rule 4	This rule checks to see if a smoking exception reporting code has been entered into the record in the last 15 months. If this is the case then the patient is exception reported. If not then the next rule is applied.
Rule 5	This rule checks to see if the earliest recording of the earliest qualifying diagnosis is recorded within the last 3 months. If this is the case then the patient is exception reported. All remaining records should be selected into the denominator.

Numerator

This rule set is applied to the denominator population identified through applying the rules described above to the register population.

Rule 1	This rule checks to see that there is a record of smoking cessation advice having been given in the last 15 months. If this is the case then the patient is selected into the numerator. If not, then the patient will not be counted in achievement against the indicator.
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Known concerns/ queries - There are no known concerns/ queries in relation to this indicator.

Issues for assessment - There are no specific issues for assessment in relation to this indicator.

Annex;

Register standards from West Midlands 2007-08 QOF Guide

Disease register construction

West Midlands – Good Practice Principle

Practices should have standards and procedures for how each disease register is set up and maintained that ensure patients are added or removed where register requirement has changed. It is important to adhere to the QOF guidance. Many practices will have developed disease registers years before QOF was established, and it would therefore be inappropriate to ask how the register was developed, only how it is maintained and accuracy is ensured.

Register development should be populated from:-

- diagnosis
- protocol encoding all significant events
- drug searches
- records review
- refer to BHS and NICE guidelines

Practices should be able to demonstrate that there is active management of the register – those based on pure codes⁴ searches may not be sufficient.

There are resolution codes for patients who may need to be removed from the register, in particular asthma and diabetes.

Assessors should use the CHART electronic audit tool for those signed up to the Information and Management Technology DES which will demonstrate data quality⁵.

Hypertension

Specific concern has been raised in respect of the hypertension register:

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

The separate occasions should be separate attendances over at least two weeks (unless the hypertension is clearly rampant). Blood pressure should be taken by a trained observer after five minutes rest with the arm horizontal.

⁴ Codes may be READ, CTV3, SNOMED CT

⁵ This DES ceases on March 31 2009

Obesity

It is recognised that the practice may find it difficult to identify patients within this group, but recognising the significant health risks associated there practitioners should recognise the benefit in working with these patients. The national prevalence is in excess of 20%. The obesity register should be populated to "include, all people whose body mass index (BMI) has been recorded in the practice as part of routine care." Therefore you would expect a practice register not to approach the national prevalence for approximately 5 years.

Palliative Care

Work under taken in the West Midlands has demonstrated that on average 1% of patients on a practice list die each year. 56% of patients die in hospital and 20% in care homes which are in contradiction to the research that indicates 91% of patients would wish to die at home. The accuracy of this register and engagement with the multidisciplinary team could improve the end of life care for a number of patients.

Thanks

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- Dr. Andrew Black, GP in Herefordshire PCT region
- Dr. John Derry GP and Professional Medical Adviser, Thames Valley Primary Care Agency
- Dr. Dave Jeffery, Former GP and now full time Primary Care Data Quality Manager, Herefordshire PCT .
- Dr. Paddy Twomey GP and Medical Secretary, Lincolnshire Local Medical Committee
- Patricia Cordery Service Manager/QOF Operational Lead Bromley PCT