

# **GMS STATEMENT OF FINANCIAL ENTITLEMENTS FOR 2004/5**

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## 1. Introduction

1.1 The Secretary of State for Health, in exercise of the powers conferred upon him by section 28T and 126(4) of the National Health Service Act 1977<sup>1</sup>, and of all other powers enabling him in that behalf, after consulting in accordance with section 28T(4) of the 1977 Act both with the bodies appearing to him to be representative of persons to whose remuneration these directions relate and with such other persons as he thinks appropriate, gives the directions set out in this Statement of Financial Entitlements (“SFE”).

1.2 This SFE relates to the payments to be made by PCTs to a contractor under a GMS contract.

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

- (a) words or expressions used here and the 1977 Act bear the meaning they bear in the 1977 Act;
- (b) references to legislation (i.e. Acts and subordinate legislation) are to that legislation as amended, extended or applied, from time to time;
- (c) words importing the masculine gender include the feminine gender, and *vice versa* (words importing the neuter gender also include the masculine and feminine gender); and
- (d) words in the singular include the plural, and *vice versa*.

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

1.5 The directions given in this SFE apply to England only (parallel Statements will be made for Scotland, Wales and Northern Ireland). They were authorised to be given, and by an instrument in writing, on behalf of the Secretary of State for Health, by Michael Munt, a member of the Senior Civil Service, on 30th March 2004, and shall come into force on 1st April 2004.

1.6 This SFE may be revised during the financial year 2004 to 2005, in accordance with section 28T(3)(e) of the 1977 Act. For the most up-to-date information, contact the Department of Health at Room 3N34A, Quarry House, Quarry Hill, Leeds, LS2 7UE, or visit the following web-site: [www.dh.gov.uk](http://www.dh.gov.uk).

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<sup>1</sup> 1977 c.49. Section 28T was inserted by section 171 of the Health and Social Care (Community Health and Standards) Act 2003 (c.43). Section 126(4) has been amended by section 65(2) of the National Health Service and Community Care Act 1990 (c.19), paragraph 37 of Schedule 4 to the Health Act 1999 (c.8) and paragraph 5(13)(b) of Schedule 5 to the Health and Social Care Act 2001 (c.15).

## PART 1

### GLOBAL SUM AND MINIMUM PRACTICE INCOME GUARANTEE

#### 2. Global Sum Payments

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

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

2.2 PCTs must calculate for each contractor the first value of its Initial Global Sum Monthly Payment ("Initial GSMP"). This calculation is to be made by first establishing the contractor's Contractor Registered Population (CRP)–

- (a) if the contract takes effect on 1st April 2004 – or is treated as taking effect for payment purposes on 1st April 2004, which will be the case for GMS contracts replacing default contracts – on that date; or
- (b) if the contract takes effect (for payment purposes) after 1st April 2004, on the date the contract takes effect.

2.3 Once the contractor's CRP has been established, this number is to be adjusted by the Global Sum Allocation Formula, a summary of which is included in Annex B of this SFE. The resulting figure, which is the contractor's Contractor Weighted Population for the Quarter, is then to be multiplied by £54. If the PCT is within the area of a London SHA, a London Adjustment is thereafter to be added, which is the contractor's CRP multiplied by £2.18.

2.4 Then, the PCT will need to add to the total produced by paragraph 2.3 (with or without the London Adjustment, as appropriate) these further amounts–

- (a) the annual amount of the contractor's Temporary Patients Adjustment. The method of calculating contractors' Temporary Patients Adjustments is set out in Annex C;
- (b) a Superannuation Premium, which is the contractor's Contractor Weighted Population for the Quarter multiplied by £0<sup>1</sup>; and
- (c) from 1st July 2004, an Appraisal Premium, which is the contractor's Contractor Weighted Population for the Quarter multiplied by £0<sup>1</sup>.

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<sup>1</sup> It is expected that the amount for the financial year 2004 to 2005 will be agreed and inserted in April 2004.

(The purpose of the appraisal premium is to contribute to the contractor's costs in respect of the appraisal of medical practitioners performing primary medical services under the GMS contract, including the costs of employing locums and the costs of preparing portfolios.)

The resulting amount is then to be divided by twelve, and the resulting amount from that calculation is the contractor's first Initial GSMP.

### Calculation of Adjusted Global Sum Monthly Payments

2.5 If the GMS contract stipulates from the outset that the contractor is not to provide one or more of the Additional or Out of Hours Services listed in column 1 of the Table in this paragraph, the PCT is calculate an Adjusted GSMP for that contractor as follows. If the contractor is not going to provide–

- (a) one of the Additional or Out of Hours Services listed in column 1 of the Table, the contractor's Adjusted GSMP will be its Initial GSMP reduced by the percentage listed opposite the service it is not going to provide in column 2 of the Table;
- (b) more than one of the Additional or Out of Hours Services listed in column 1 of the Table, an amount is to be deducted in respect of each service it is not going to provide. The value of the deduction for each service is to be calculated by reducing the contractor's Initial GSMP by the percentage listed opposite that service in column 2 of the Table, without any other deductions from the Initial GSMP first being taken into account. The total of all the deductions in respect of each service is then deducted from Initial GSMP to produce the Adjusted GSMP.

**TABLE**

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

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<sup>1</sup> It is expected that the amount for the financial year 2004 to 2005 will be agreed and inserted in April 2004.

### ***First Payable Global Sum Monthly Payment***

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

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

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

### ***Revision of Payable Global Sum Monthly Payment***

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

- (a) at the start of each quarter (when the contractor may have a new Contractor Weighted Population for the Quarter);
- (b) if there are to be new Additional or Out of Hours Services opt-outs (whether temporary or permanent); or
- (c) if the contractor is to start or resume providing specific Additional Services that it has not been providing.

2.9 Whenever the Payable GSMP needs to be revised, the PCT will first need to calculate a new Initial GSMP for the contractor (unless this cannot have changed). This is to be calculated in the same way as the contractor's first Initial GSMP (as outlined in paragraphs 2.3 and 2.4 above) but—

- (a) using the most recently established CRP of the contractor (the number is to be established quarterly); and
- (b) from 1st July 2004, adding in the Appraisal Premium.

2.10 Any deductions for Additional or Out of Hours Services opt-outs are then to be calculated in the manner described in paragraph 2.5. If the contractor starts or resumes providing specific Additional Services under its GMS contract to patients it is required to provide essential services to then any deduction that had been made in

respect of those services will need to be reversed. The resulting amount (if there are to be any deductions in respect of Additional or Out of Hours Services) is the contractor's new (or possibly first) Adjusted GSMP.

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

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

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

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

#### ***Conditions attached to Payable Global Sum Monthly Payments***

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

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

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

2.16 It is also a condition of every contractor's Payable GSMPs that it achieves in respect of the financial year 2004 to 2005 an Achievement Points Total of at least 100. If it breaches this condition, the PCT must withhold from the contractor £7,500 multiplied by its Contractor Population Index (i.e. for the last quarter) in respect of its Payable GSMPs for the financial year 2004 to 2005 (the contractor will, however, receive an Achievement Payment in respect of the points it does score pursuant to paragraph 5.39).

2.17 However, if the contractor's GMS contract either takes effect after 1st April 2004 or is terminated before 31st March 2005, the amount to be withheld pursuant to paragraph 2.16 is to be adjusted by the fraction produced by dividing the number of days during which the financial year 2004 to 2005 for which its GMS contract had effect by 365.

### **3. Minimum Practice Income Guarantee**

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

#### ***Calculation of Global Sum Equivalent***

3.2 In order to calculate a contractor's GSE, a calculation will first need to be made of its Initial and Adjusted GSE. This is to be done by the PCT—

- (a) on the basis of information obtained by it from the contractor about payments to the contractor (or the GPs comprising the contractor) under the Red Book, and in particular in the year preceding 1st July 2003; and
- (b) in accordance with the Department of Health guidance reproduced in Annex D. Paragraphs 1 – 7 cover the calculation of the Initial GSE, and adjustments to take account, for example, of practice mergers and splits are covered in paragraphs 8 – 19.

3.3 Whether or not any adjustments are in fact necessary to the Initial GSE, the final total produced as a result of the calculation in accordance with Annex D is known as the contractor's Adjusted GSE. That amount is then subject to three further adjustments–

- (a) the amount is increased by 2.85% to bring prices in respect of the year ending 30th June 2003 up to 31st March 2004 levels (i.e. rebasing for the financial year 2003 to 2004); then
- (b) the sub-paragraph (a) amount is increased by 1.47% to take account of projected price increases in respect of the financial year 2004 to 2005 (i.e. rebasing for the financial year 2004 to 2005); then
- (c) the sub-paragraph (b) amount is added to the contractor's GSE Superannuation Adjustment. This is an adjustment to take account of the additional 7% employer's superannuation contributions in respect of practice staff as a result of the Treasury transfer. The contractor's GSE Superannuation Adjustment is its Contractor Weighted Population for the Quarter multiplied by £1.46.

The resulting amount is the contractor's Final GSE.

#### ***Calculation of Correction Factor Monthly Payments***

3.4 The contractor's Final GSE is then to be compared to the paragraph 2.3 total in respect of the contractor taking away from that paragraph 2.3 total any Historic Opt-Outs Adjustment to which it is entitled.

3.5 A contractor is entitled to the Historic Opt-Outs Adjustment if–

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

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

- (a) one of the Additional or Out of Hours Services listed in column 1 of the Table in paragraph 2.5, the value of the contractor's Historic Opt-Outs Adjustment is the amount by which its paragraph 2.3 total is reduced if it is reduced by the percentage listed opposite that service in column 2 of the Table;
- (b) more than one of the Additional or Out of Hours Services listed in column 1 of the Table in paragraph 2.5, the value of the contractor's Historic Opt-Outs Adjustment is to include an amount in respect of each service. The value of the amount for each service is the amount by which the contractor's paragraph 2.3 total is reduced if it is reduced by the percentage listed opposite that service in column 2 of the Table, without any other deductions from the paragraph 2.3 total first being taken into account. The total of all the amounts in respect of each service is then aggregated to produce the final amount of the contractor's Historic Opt-Outs Adjustment.

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

3.8 If the contractor's Final GSE is less than its Global Sum Comparator, a Correction Factor is not payable in respect of that contractor. However, if its Final GSE is greater than its Global Sum Comparator, Correction Factor Monthly Payments ("CFMPs") must be paid by the PCT to the contractor under its GMS contract. The amount of the CFMPs payable is the difference between the contractor's Final GSE and its Global Sum Comparator, divided by twelve. CFMPs are to fall due on the last day of each month.

3.9 Unless the contractor is subject to a partnership merger or split, the amount of the contractor's CFMPs is to remain unchanged throughout the financial year 2004 to 2005, even if the amount of the contractor's Payable GSMP changes.

#### ***Practice mergers or splits***

3.10 The MPIG calculation is a one-off calculation, which will remain unchanged. It is only to be made in respect of GMS contracts that take effect, or are treated as taking effect, on 1st April 2004. Except as provided for in paragraphs 3.11 to 3.14, a contractor with a GMS contract which takes effect, or is treated as taking effect, after 1st April 2004 will not be entitled to an MPIG (or therefore to CFMPs).

3.11 If the new contractor comes into existence as the result of a merger between one or more other contractors, and that merger led to the termination of GMS contracts and the agreement of a new GMS contract, the new contractor is to be entitled to a CFMP that is the total of any CFMPs payable under the previous GMS contracts.

3.12 If-

- (a) a new contractor comes into existence as the result of the split of a previous contractor;
- (b) at least some of the members of the new contractor were members of the previous contractor; and
- (c) the split led to the termination of the previous contractor's GMS contract,

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

3.13 If a new GMS contract is agreed by a contractor which has split from a previously established contractor, but the split did not lead to the termination of the previously established contractor's GMS contract, the new contractor will not be entitled to any of the previously established contractor's CFMP unless, as a result of the split, an agreed number, or a number ascertainable by the PCT(s) for the contractors, of patients have transferred to the new contractor at or before the end of the first full quarter after the new GMS contract takes effect.

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

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

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

***Conditions attached to payment of Correction Factor Monthly Payments***

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

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

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

***Future years***

3.17 In future years, Correction Factor Payments will be updated by the same percentage as Global Sum Payments.

## **PART 2**

### **QUALITY AND OUTCOMES FRAMEWORK**

#### **4. Quality Preparation Payments**

4.1 Quality Preparation Payments are to fund the initial collection of data to establish the contractor's current position, and to assist contractors in preparing for the Quality and Outcomes Framework ("QOF"), which is Annex E to this SFE.

4.2 Individual practitioners will have received a Quality Preparation Payment during the financial year 2003 to 2004 as a Standard Capitation Fee Supplement. For the financial year 2004 to 2005, as capitation fees have been abolished, the way in which Quality Preparation Payments are paid is to change.

##### *Calculation of Quality Preparation Payments*

4.3 The Quality Preparation Payment is an annual amount. In order to calculate it, the PCT must first establish the CRP of the contractor–

- (a) if the contract takes effect on 1st April 2004 – or is treated as taking effect for payment purposes on 1st April 2004, which will be the case for GMS contracts replacing default contracts – on that date; or
- (b) if the contract takes effect (for payment purposes) after 1st April 2004, on the date the contract takes effect.

4.4 From this number, the contractor's Contractor Population Index is to be calculated (which is the number produced by dividing a contractor's most recently established CRP by 5891). The contractor's CPI is then multiplied by £3,250 which, unless the contract takes effect after 1st April 2004, is the amount of the contractor's Quality Preparation Payment.

4.5 If the contract takes effect after 1st April 2004, the amount is to be adjusted by the fraction produced by dividing the number of days during the financial year 2004 to 2005 for which the contract is to have effect by 365.

4.6 Once the amount of a contractor's Quality Preparation Payment has been established, the PCT must pay it to the contractor under its GMS contract. The payment is to fall due at the same time as the contractor's first Payable GSMP falls due.

##### *Condition attached to quality preparation payments*

4.7 Quality Preparation Payments are only payable in respect of GMS contracts that take effect on or before 1st February 2005 if the contractor agrees an Aspiration Points Total with the PCT for the financial year 2004 to 2005. They are only payable

in respect of GMS contracts agreed after 1st February 2005 if the contractor has agreed to participate in the QOF.

## **5. Aspiration and Achievement Payments**

5.1 Participation in the QOF is voluntary, and if a contractor decides not to participate in the QOF, this Section will not apply to it.

5.2 Aspiration Payments are payments based on the total number of points that a contractor has agreed with a PCT that it is aspiring towards under the QOF during the financial year 2004 to 2005. This total is its Aspiration Points Total. The points available are set out in the QOF indicators in the QOF, which have numbers of points attached to particular performance indicators (negative points totals in relation to indicators are always to be disregarded).

5.3 If a contractor is to have an Aspiration Points Total, this is to be agreed between it and the PCT for when its contract takes effect. However, if the contract is to take effect on or after 2nd February 2005, no Aspiration Points Total is to be agreed for the financial year 2004 to 2005. Contractors which do not have an Aspiration Points Total will nevertheless be entitled to Achievement Payments under the QOF if they participate in the QOF.

5.4 Achievement Payments are payments based on the points total that the contractor achieves under the QOF during the financial year 2004 to 2005 (which is its Achievement Points Total). The payments are to be made in respect of all Achievement Points actually achieved, whether or not the contractor was seeking to achieve those points when its Aspiration Points Total was agreed.

### **CALCULATION OF POINTS TOTALS**

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

#### ***Calculation of points in the clinical domain***

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

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

5.8 Other indicators have designated Achievement Thresholds. The contractor's performance against the standards set out in these indicators is assessed by a

percentage – generally of the patients suffering from a particular disease in respect of whom a specific task is to be performed or a specific outcome recorded. Two percentages are set in relation to each indicator–

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

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

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

- (a) the number of patients registered with the contractor in respect of whom the task has been performed or outcome achieved (A); by
- (b) the number produced by subtracting from the total number of patients registered with the contractor with the relevant medical condition (B) the number of patients to be excluded from the calculation on the basis of the provisions in the QOF on exception reporting (C).

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

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

$$\frac{(D - E)}{(F - E)} \times G.$$

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

### ***Calculation of points in the organisational domain***

5.13 This domain is itself split into five further sub-domains: records and information about patients; information for patients; education and training; practice

management; and medicines management. Section 3 of the QOF contains a number of indicators for each of these sub-domains, which in turn contain standards against which the performance of the contractor will be assessed.

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

#### ***Calculation of points in the patient experience domain***

5.15 This domain, in Section 4 of the QOF, contains essentially two indicators, both of which relate to patient experience: the first is about the length of patient consultations; the second, split into three levels, is about patient surveys.

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

5.17 The points available in relation to the second indicator will only be obtainable if–

- (a) the task set out in the lowest performance level is accomplished, i.e. the contractor has undertaken an approved patient survey; and
- (b) in the course of that survey, at least 25 questionnaires per 1000 patients registered with the contractor have been returned by patients.

For each additional level of performance that is reached, the additional points available in relation to that level are obtainable, so a contractor reaching the highest level of performance achieves the points available for all three levels of performance.

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

#### ***Calculation of points in the additional services domain***

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

5.20 The child health surveillance and maternity medical services indicators require particular services to be offered – and the points available in relation to these indicators will only be obtainable (and then in full) if the service is offered to the relevant target population. The contraceptive services indicators and all but one of the cervical screening services indicators require particular tasks to be performed in relation to a target population, and the points available in relation to these indicators will only be obtainable (and then in full) if the task is accomplished. One of the

cervical screening services indicators has a designated achievement threshold, and the method for calculating points in relation to this indicator is the same as the method for calculating points in relation to this type of indicator in the clinical domain. Guidance on what is required to gain the points set out in this domain is given in Section 5 of the QOF and Annex F.

### ***Calculation of points in relation to the Holistic Care Payment***

5.21 Contractors will be entitled to a proportion of 100 points as the basis of a Holistic Care Payment. This is a payment designed to recognise breadth of achievement across the clinical domain.

5.22 In order to calculate the points in respect of this Payment, the contractor's points totals in each of the clinical areas in the clinical domain are to be ranked on the basis of the proportion it scores of the points available in that clinical area, the highest proportion being ranked first. The proportion that is third-to-last is the proportion of 100 points to which it is entitled as the basis of its Holistic Care Payment.

### ***Calculation of points in relation to the Quality Practice Payment***

5.23 Contractors will also be entitled to a proportion of 30 points as the basis of a Quality Practice Payment, designed to recognise breadth of achievement across the organisational, patient experience and additional services domains.

5.24 In order to calculate the points in respect of this Payment, the contractor's points totals in each of the sub-domains in the organisational, patient experience and additional services domains are to be ranked on the basis of the proportion it scores of the points available in that sub-domain, the highest proportion being ranked first. For these purposes, the sub-domains—

- (a) in the organisational domain are under the headings—
  - (i) records and information about patients,
  - (ii) information for patients,
  - (iii) education and training,
  - (iv) practice management, and
  - (v) medicines management;
- (b) in the patient experience domain are the length of consultations indicator and the patient survey indicator. For the patient survey indicator, the ranked proportion is to be the proportion of the maximum number of points available in relation to this indicator (i.e. if the highest performance level is achieved); and
- (c) in the additional services domain are the four different additional services in that domain.

5.25 The proportion that is ranked third-to-last is the proportion of 30 points to which it is entitled as the basis of its Quality Practice Payment. Additional services which the contractor does not provide must nevertheless be included in the ranking.

#### ***Calculation of points in relation to QOF Access Payment***

5.26 The relevant access targets are those referred to in paragraph 6.1(a). Achievement in relation to these targets in the four months from December 2004 to March 2005 inclusive will enable contractors to score up to 8 data points (4 in relation to access to GPs and 4 in relation to access to health care professionals) under the Primary Care Access Survey during that four month period. Practices scoring–

- (a) 6, 7 or 8 data points in respect of achieving these access targets during that period;
- (b) at least 3 data points in relation to access to GPs during that period;  
and
- (c) at least 3 points in relation to access to health care professionals during that period,

will be entitled to 50 points as the basis of a QOF Access Payment.

### **CALCULATION OF PAYMENTS**

#### ***Calculation of Monthly Aspiration Payments***

5.27 Aspiration Payments are based on a contractor's Aspiration Points Total. As indicated in paragraph 5.3, if a contractor is to have an Aspiration Points Total for the financial year 2004 to 2005, this is to be agreed between it and the PCT for when its contract takes effect.

5.28 If the PCT and the contractor have agreed an Aspiration Points Total for the contractor, that total is to be divided by three. The resulting figure is to be multiplied by £75, and then by the contractor's CPI. The resulting amount, which is the annual amount of the contractor's Aspiration Payment, is then to be divided by twelve for the contractor's Monthly Aspiration Payment.

5.29 The PCT must thereafter pay the contractor under its GMS contract its Monthly Aspiration Payment monthly. The Monthly Aspiration Payment is to fall due on the last day of each month. However, if the contractor's contract took effect on a day other than the first day of a month, its Monthly Aspiration Payment in respect of that first part month is to be adjusted by the fraction produced by dividing–

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

5.30 The amount of a contractor's Monthly Aspiration Payments is thereafter to remain unchanged throughout the financial year 2004 to 2005, even when its CPI changes or if the contractor ceases to provide an Additional Service and as a consequence is less likely to achieve the Aspiration Points Total that has been agreed.

***Conditions attached to Monthly Aspiration Payments***

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

- (a) the contractor's Aspiration Points Total on which the Payments are based must be realistic, agreed with the PCT and broken down for the PCT by the contractor into a standard format, provided nationally;
- (b) the contractor must make available to the PCT any information which the PCT does not have but needs, and the contractor either has or could reasonably be expected to obtain, in order to calculate the contractor's Monthly Aspiration Payments;
- (b) the contractor must make any returns required of it (whether computerised or otherwise) to the Exeter Registration System, and do so promptly and fully;
- (d) once it is possible for accredited computer systems to generate monthly returns relating to achievement of the standards contained in the indicators in the QOF–
  - (i) contractors utilising accredited computer systems must make available to the PCT anonymised, aggregated monthly returns relating to their achievement of the standards contained in the indicators in the QOF, and in the standard form provided for by such systems, and
  - (ii) contractors not utilising accredited computer systems must make available to the PCT similar monthly returns, in such form as the PCT reasonably requests (for example, PCTs may reasonably request that contractors fill in manually a printout of the standard spreadsheet which is produced by accredited systems in respect of monthly achievement of the standards contained in the indicators in the QOF);
- (e) from December 2004, the contractor must make available to the PCT, under the Primary Care Access Survey, returns relating to its data points scores in relation to the access targets referred to in paragraph 6.1(a); and
- (f) all information supplied pursuant to or in accordance with this paragraph must be accurate.

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

### ***Payment of Achievement Payments***

5.33 Achievement Payments are to be based on the Achievement Points Total to which a contractor is entitled at the end of the financial year 2004 to 2005, as calculated in accordance with this Section.

5.34 The date in respect of which the assessment of achievement points is to be made is 31st March 2005, subject to the following exceptions–

- (a) as indicated in paragraph 5.26 above, the arrangements for making the assessment in respect of the QOF Access Payment are different. Achievement of the access targets will be assessed over a four month period from December 2004 to March 2005 inclusive;
- (b) if a contractor is under an obligation, under its GMS contract, to provide an additional service for part of the financial year but ceases providing that service before the end of the financial year–
  - (i) permanently, or
  - (ii) temporarily, but does not then resume providing the service before the end of the financial year,

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

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

5.35 In order to make a claim for an Achievement Payment, a contractor must make a return in respect of the information required of it by the PCT in order for the PCT to calculate its Achievement Payment.

5.36 On the basis of that return, but subject to any revision of the Achievement Points total that the PCT may reasonably see fit to make–

- (a) to correct the accuracy of any points total; or
- (b) having regard to any guidance issued by the Department of Health,

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

5.37 The parts of the Achievement Payment that relate to the clinical domain and the additional services domain are calculated in a different way from the parts relating to the other domains. As regards–

- (a) the clinical domain, first a calculation needs to be made of an Adjusted Practice Disease Factor for each disease area, and this is then multiplied by £75 and by the contractor's Achievement Points total in respect of the disease area to produce a cash amount for that disease area. Then the cash totals in respect of all the individual disease areas in the domain are to be added together to give the cash total in respect of the domain. A fuller explanation of the calculation of Adjusted Practice Disease Factors is given in Annex G; and
- (b) the additional services domain, the Achievement Points total in respect of each additional service is to be assessed in accordance with the guidance in Annex F, and a calculation is to be made of the cash total in respect of that domain in the manner set out in that guidance.

5.38 As regards all the other Achievement Points gained by the contractor, the total number of them is to be multiplied by £75.

5.39 The cash totals produced under paragraphs 5.37 and 5.38 are then added together and multiplied by the contractor's CPI–

- (a) at the start of the final quarter of the financial year 2004 to 2005;
- (b) if its contract takes effect after the start of the final quarter of the financial year 2004 to 2005, on the date the contract takes effect; or
- (c) if its contract has terminated, its CPI immediately before the contract terminated (i.e. its most recently established list size).

5.40 If the contractor's GMS contract had effect–

- (a) throughout the financial year 2004 to 2005, the resulting amount is the provisional total for the contractor's Achievement Payment for the financial year 2004 to 2005; or
- (b) for only part of the financial year 2004 to 2005, the resulting amount is to be adjusted by the fraction produced by dividing the number of days during the financial year 2004 to 2005 for which the contractor's GMS contract had effect by 365, and the result of that calculation is the provisional total for the contractor's Achievement Payment for the financial year 2004 to 2005.

5.41 From these provisional totals, the PCT needs to subtract the total value of all the Monthly Aspiration Payments made to the contractor under its GMS contract in the financial year 2004 to 2005. The resulting amount (unless it is a negative amount

or zero, in which case no Achievement Payment is payable) is the contractor's Achievement Payment for the financial year 2004 to 2005.

5.42 This Achievement Payment is to be treated for accounting and superannuation purposes as gross income of the contractor in the financial year 2004 to 2005 but is to fall due—

- (a) if the PCT is considering revising the contractor's Achievement Points Total in accordance with paragraph 5.36, on 30th June 2005; and
- (b) in all other cases, on 30th April 2005.

***Conditions attached to Achievement Payments***

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

- (a) the contractor must make the return required of it under paragraph 5.35;
- (b) the contractor must ensure that all the information that it makes available to the PCT in respect of the calculation of its Achievement Payment is based on accurate and reliable information, and that any calculations it makes are carried out correctly;
- (c) the contractor must ensure that it is able to provide any information that the PCT may reasonably request of it to demonstrate that it is entitled to each Achievement Point to which it says it is entitled, and the contractor must make that information available to the PCT on request;
- (d) the contractor must make any returns required of it (whether computerised or otherwise) to the Exeter Registration System, and do so promptly and fully;
- (e) the contractor must co-operate fully with any reasonable inspection or review (including the PCT's QOF annual review) that the PCT or another relevant statutory authority wishes to undertake in respect of the Achievement Points to which it says it is entitled; and
- (f) all information supplied pursuant to or in accordance with this paragraph must be accurate.

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

## PART 3

### DIRECTED ENHANCED SERVICES

#### 6. Improved Access Scheme

6.1 Direction 3(1)(a) of the DES Directions requires each PCT to establish (if it has not already done so), operate and, as appropriate, revise an Improved Access Scheme for its area, the underlying purpose of which is to improve patient access to primary medical services, and which may comprise or include—

- (a) arrangements for ensuring that patients requiring routine appointments will, on request, be able to see face-to-face, by the end of—
  - (i) the first normal working day after the day on which the request was made, a health care professional, and
  - (ii) the second normal working day after the day on which the request was made, a general practitioner; and
- (b) arrangements to address specific local health needs or requirements in respect of access to primary medical services locally.

6.2 As part of its Improved Access Scheme, a PCT must, each financial year, offer to enter into arrangements with each contractor in its area (unless it already has such arrangements with the contractor in respect of that financial year), thereby affording the contractor a reasonable opportunity to participate in the Scheme during that financial year. However, before entering into any such arrangements, the PCT must satisfy itself of the matters set out in direction 3(2)(a) and (b) of the DES Directions.

6.3 The plan setting out any arrangements that the PCT enters into, or has entered into, with a particular contractor (“an IAS plan”) must cover the matters set out in direction 4(2) (a) to (d) of the DES Directions.

#### *Improved Access Scheme Implementation Payments*

6.4 If, as part of a GMS contract, a contractor and a PCT have agreed an IAS plan, the PCT must in respect of the financial year 2004 to 2005 pay to the contractor under its GMS contract an Improved Access Scheme Implementation Payment of £2,580.50 multiplied by the contractor’s CPI. This amount is to fall due—

- (a) if the plan is agreed on or was agreed before 1st April 2004, on 30th April 2004; and
- (b) if the plan is agreed after 1st April 2004, on the first date after the plan is agreed on which one of the contractor’s Payable GSMPs falls due.

### ***Improved Access Scheme Reward Payments***

6.5 If, as part of a GMS contract a contractor and a PCT have agreed an IAS plan, the PCT must in respect of the financial year 2004 to 2005 pay to the contractor under its GMS contract an Improved Access Scheme Reward Payment if, in the reasonable opinion of the PCT, during that financial year the contractor has fulfilled its obligations under that plan.

6.6 If the plan—

- (a) is agreed on or was agreed before 1st April 2004 and has effect for the whole of the financial year 2004 to 2005, the amount payable is £2,580.50, multiplied by the contractor's CPI at the start of the last quarter;
- (b) has effect for only part of the financial year 2004 to 2005, the amount payable is £2,580.50, multiplied by—
  - (i) the contractor's CPI either for the last quarter or, if the plan ceases to have effect before 1st January 2005, for when the plan ceased to have effect, and
  - (ii) the fraction produced by dividing the number of days for which the plan had effect during the financial year 2004 to 2005 by 365.

6.7 The payment is to be treated for accounting and superannuation purposes as gross income of the contractor in the financial year 2004 to 2005 but is to fall due on 30th April 2005.

6.8 Improved Access Scheme Reward Payments, or any part thereof, are only payable if the contractor satisfies the following conditions—

- (a) the contractor must make available to the PCT any information which the PCT does not have but needs, and the contractor either has or could reasonably be expected to obtain, in order to form its opinion on whether the contractor has fulfilled its obligations under the IAS plan;
- (b) the contractor must make any returns required of it (whether computerised or otherwise) to the Exeter Registration System, and do so promptly and fully; and
- (c) all information supplied pursuant to or in accordance with this paragraph must be accurate.

6.9 If the contractor breaches any of these conditions, the PCT may, in appropriate circumstances, withhold payment of any or any part of an Improved Access Scheme Reward Payment that is otherwise payable.

## **7. Quality Information Preparation Scheme**

7.1 Direction 3(1)(b) of the DES Directions requires each PCT to establish (if it has not already done so), operate and, as appropriate, revise a Quality Information Preparation Scheme (QuIPS) for its area, the underlying purpose of which is to summarise and improve the quality of medical records held by PMS or GMS contractors in its area. QuIPSs are to come to an end on 31st March 2005.

7.2 As part of its QuIPS, a PCT must, in respect of the financial year 2004 to 2005 offer to enter into arrangements with each contractor in its area (unless it already has such arrangements with the contractor), thereby affording the contractor a reasonable opportunity to participate in the Scheme. However, before entering into any such arrangements, the PCT must satisfy itself of the matters set out in direction 3(2)(a) and (b) of the DES Directions.

7.3 The plan setting out the arrangements that the PCT enters into with a particular contractor (a “QuIPS plan”) must cover the matters set out in direction 5(2)(a) and (b) of the DES Directions.

### ***Quality Information Preparation Scheme Payments***

7.4 If, as part of a GMS contract a contractor and a PCT have agreed a QuIPS plan under which payment is due in respect of the financial year 2004 to 2005, the PCT must in respect of the financial year 2004 to 2005 pay to the contractor under the GMS contract a QuIPS Payment. The amount of this payment is to be—

- (a) not less than £1,000 multiplied by the contractor’s CPI; but
- (b) not more than £5,000 multiplied by the contractor’s CPI.

7.5 The precise figure is to depend on the amount of work that needs doing, having regard to the fact that QuIPS payments are not intended to cover the full cost of ensuring that contractors’ records are appropriately summarised and edited.

7.6 The payment is to fall due—

- (a) if the plan was agreed on or before 1st April 2004, or takes effect on 1st April 2004, on 30th April 2004; and
- (b) if the plan is agreed after 1st April 2004, on the first date after the plan is agreed on which one of the contractor’s Payable GSMPs falls due.

## **8. Childhood Immunisations Scheme**

8.1 Childhood Immunisation and Pre-school Booster Services are classified as Additional Services. If contractors are providing these services to patients registered with them, PCTs are to seek to agree a Childhood Immunisations Scheme plan with

them, as part of their GMS contract. This plan will be the mechanism under which the payments set out in this Section will be payable.

### ***Childhood Immunisations Scheme plans***

8.2 Childhood Immunisations Scheme plans are to cover the matters set out in direction 6(2)(a) to (g) of the DES Directions.

### ***Target payments in respect of two-year-olds***

8.3 PCTs must in respect of the financial year 2004 to 2005 pay to a contractor under its GMS contract a Quarterly Two-Year-Olds Immunisation Payment (“Quarterly TYOIP”) if it qualifies for that payment. A contractor qualifies for that payment if–

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

### ***Calculation of Quarterly Two-Year-Olds Immunisation Payment***

8.4 PCTs will first need to determine the number of completed immunisation courses that are required over the four disease groups in paragraph 8.3(b) in order to meet either the 70% or 90% target. To do this the contractor will need to provide the PCT with the number of two-year-olds (**A**) whom it is under a contractual obligation to include in its Childhood Immunisations Scheme Register on the first day of the quarter in respect of which the contractor is seeking payment (the head count will in fact relate to children registered with the contractor at the start of the previous quarter), and then the PCT must make the following calculations–

- (a)  $(0.7 \times \mathbf{A} \times 4) = \mathbf{B}^1$  (the number of completed immunisations needed to meet the 70% target); and

- (b)  $(0.9 \times A \times 4) = B^2$  (the number of completed immunisations needed to meet the 90% target).

8.5 PCTs will then need to calculate which, if any, target was achieved. To do this, a PCT will also need from the contractor the sum of the total number of children aged two whom it is under a contractual obligation to include in its Childhood Immunisations Scheme Register and who have completed immunisations in each of the four groups ( $C^{01-4}$ ). Only completed immunisation courses (whether or not carried out by the contractor) are to count towards the determination of whether or not the targets are achieved. No adjustment is to be made for exception reporting. A calculation is then to be made of whether or not the targets are achieved—

- (a) if  $C^{01-4} \leq B^1$ , then the 70% target is achieved; and  
 (b) if  $C^{01-4} \leq B^2$ , then the 90% target is achieved.

8.6 Next the PCT will need to calculate the number of the completed immunisations that the contractor can use to count towards achievement of the targets (**D**). To do this, the contractor will need to provide the PCT with a breakdown of how many of the completed immunisation courses in each disease group were carried out by it, or by another GMS or PMS contractor, within the NHS.

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

$$\begin{array}{r}
 C^{01} \quad - \quad E^{01} \\
 C^{02} \quad - \quad E^{02} \\
 C^{03} \quad - \quad E^{03} \\
 + \quad C^{04} \quad - \quad E^{04} \\
 \hline
 = \quad \quad \quad D
 \end{array}$$

For these purposes—

- (a) ( $E^{0x}$ ) is the number of completed immunisation carried out other than by a GMS or PMS contractor for the NHS in each group (i.e. for Group 1,  $E^{01}$ ); and  
 (b) in each case the sum of  $C^{0x} - E^{0x}$  can never be greater than  $C^{0x} \times [0.7]$  or  $[0.9]$  (depending on which target achieved). Where it is, it is treated as the result of:  $C^{0x} \times [0.7]$  or as the case may be  $[0.9]$ .

8.8 In the financial year 2004 to 2005, the maximum amounts payable to a contractor will depend on the number of children aged two whom it is under a contractual obligation to include in its Childhood Immunisations Scheme Register on the first day of each quarter compared with the average UK number of such children per 5000 population, which is 59.25. The maximum amounts payable to the contractor (**F**) are therefore to be calculated as follows—

- (a) where the 70% target is achieved:  $(F^1) = \frac{A}{59.25} \times \text{£}685.25$ ; and

(b) where the 90% target is achieved:  $(F^2) = \frac{A}{59.25} \times \text{£}2,055.75$

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

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

8.10 The amount payable as a Quarterly TYOIP is to fall due on the last day of the quarter in respect of which the contractor is seeking payment (i.e. at the end of the quarter after the last quarter in which immunisations were carried out that count towards the targets). However, if the contractor delays providing the information the PCT needs to calculate its Quarterly TYOIP beyond the middle of the quarter, the amount is to fall due at the end of the next quarter. No Quarterly TYOIP is payable if the contractor provides the necessary information more than four months after the date to which the information relates.

#### ***Conditions attached to Quarterly Two-Year-Olds Immunisation Payments***

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

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

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

### *Target payments in respect of five-year-olds*

8.13 PCTs must in respect of the financial year 2004 to 2005 pay to a contractor under its GMS contract a Quarterly Five-Year-Olds Immunisation Payment (“Quarterly FYOIP”) if it qualifies for that payment. A contractor qualifies for that payment if–

- (a) as part of its GMS contract the contractor and the PCT have agreed a Childhood Immunisation Scheme plan; and
- (b) on the first day of the quarter to which the payment relates, at least 70%, for the lower payment, or at least 90%, for the higher payment, of the children aged five (i.e. who have passed their fifth birthday but not yet their sixth) registered with the contractor have received the recommended reinforcing doses (i.e. those that have been recommended nationally and by the World Health Organisation) for protection against diphtheria, tetanus, acellular pertussis and poliomyelitis.

### *Calculation of Quarterly Five-Year-Olds Immunisation Payment*

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

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

8.15 PCTs will then need to calculate which, if any, target was achieved. To do this, a PCT will also need from the contractor the sum of the total number of children aged five whom it is under a contractual obligation to include in its Childhood Immunisations Scheme Register and who have completed the booster courses required (**C**). Only completed booster courses (whether or not carried out by the contractor) are to count towards the determination of whether or not the target was achieved. No adjustment is to be made for exception reporting. A calculation is then to be made of whether or not the targets are achieved–

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

8.16 Next the PCT will need to calculate the number of the completed booster courses that the contractor can use to count towards achievement of the targets (**D**), the initial value of which is (**C**) minus the number of children whose completed booster courses were not carried out by a GMS or PMS contractor within the NHS. To do this, the contractor will need to provide the PCT with a breakdown of how many of the completed booster courses were carried out by it, or by another GMS or PMS contractor, within the NHS.

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

8.18 In the financial year 2004 to 2005, the maximum amounts payable to a contractor will depend on the number of children aged five whom it is under a contractual obligation to include in its Childhood Immunisations Scheme Register on the first day of each quarter compared with the average UK number of such children per 5000 population, which is 61.45. The maximum amounts payable to the contractor (**E**) are therefore to be calculated as follows–

(a) where the 70% target is achieved:  $E^1 = \frac{A}{61.45} \times \text{£}212.25$ ; or

(b) where the 90% target is achieved:  $E^2 = \frac{A}{61.45} \times \text{£}636.75$

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

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

8.20 The amount payable as a Quarterly FYOIP is to fall due on the last day of the first month of the quarter in respect of which the contractor is seeking payment (i.e. at the end of the quarter after the last quarter in which booster courses were carried out that count towards the targets). However, if the contractor delays providing the information the PCT needs to calculate its Quarterly FYOIP beyond the middle of the quarter, the amount is to fall due at the end of the next quarter. No Quarterly FYOIP is payable if the contractor provides the necessary information more than four months after the date to which the information relates.

### ***Conditions attached to Quarterly Five-Year-Olds Immunisation Payments***

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

- (a) the contractor must meet its obligations under its Childhood Immunisation Scheme plan;
- (b) the contractor must supply to the PCT with sufficient information to enable the PCT to calculate the contractor's Quarterly FYOIP. In particular, the contractor must supply the following figures–

- (i) the number of five-year-olds whom it is under a contractual obligation to include in its Childhood Immunisations Scheme Register on the first day of each quarter,
  - (ii) how many of those five-year-olds have received the complete course of recommended reinforcing doses (i.e. that have been recommended nationally and by the World Health Organisation) for protection against diphtheria, tetanus, acellular pertussis and poliomyelitis, and
  - (iii) of those completed courses, how many were carried out by a GMS or PMS contractor within the NHS; and
- (c) all information supplied pursuant to or in accordance with this paragraph must be accurate.

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

## **PART 4**

### **PAYMENTS FOR SPECIFIC PURPOSES**

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

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

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

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

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

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

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

- (a) the leave of absence is for more than one week (the maximum periods are: 26 weeks for ordinary maternity leave and for ordinary adoption leave for the parent who is the main care provider; and 2 weeks for paternity leave and for adoption leave for the parent who is not the main care provider);
- (b) the performer on leave is entitled to that leave either under–
  - (i) statute,
  - (ii) a partnership agreement or other agreement between the partners of a partnership, or

- (iii) a contract of employment, provided that the performer on leave is entitled under their contract of employment to be paid their full salary by the contractor during their leave of absence;
- (c) the locum is not a partner or shareholder in the contractor, or already an employee of the contractor, unless the performer on leave is a job-sharer; and
- (d) the contractor is not also claiming another payment for locum cover in respect of the performer on leave pursuant to this Part,

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

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

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

#### ***Ceilings on the amounts payable***

9.5 The maximum amount payable under this Section by the PCT in respect of locum cover for a GP performer is £948.33 per week.

#### ***Payment arrangements***

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

#### ***Conditions attached to the amounts payable***

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

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

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

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

## **10. Payments for locums covering sickness leave**

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

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

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

***Entitlement to payments for covering sickness leave***

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

- (a) the leave of absence is for more than one week;
- (b) if the performer on leave is employed by the contractor, the contractor must—
  - (i) be required to pay statutory sick pay to that performer, or
  - (ii) be required to pay the performer on leave his full salary during absences on sick leave under his contract of employment;
- (c) if the GP performer's absence is as a result of an accident, the contractor must be unable to claim any compensation from whoever caused the accident towards meeting the cost of engaging a locum to cover for the GP performer during the performer's absence. But if such compensation is payable, the PCT may loan the contractor the cost of the locum, on the condition that the loan is repaid when the compensation is paid unless—
  - (i) no part of the compensation paid is referable to the cost of the locum, in which case the loan is to be considered a reimbursement by the PCT of the costs of the locum which is subject to the following provisions of this Section, or
  - (ii) only part of the compensation paid is referable to the cost of the locum, in which case the liability to repay shall be proportionate to the extent to which the claim for full reimbursement of the costs of the locum was successful;
- (d) the locum is not a partner or shareholder in the contractor, or already an employee of the contractor, unless the performer on leave is a job-sharer; and
- (e) the contractor is not already claiming another payment for locum cover in respect of the performer on leave pursuant to this Part,

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

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

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

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

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

#### ***Ceilings on the amounts payable***

10.5 The maximum amount payable under this Section by the PCT in respect of locum cover for a GP performer is £948.33 per week.

10.6 However, in any twelve month period, the maximum periods in respect of which payments under this Section are payable in relation to a particular GP performer are–

- (a) 6 months for the full amount of the sum that the PCT has determined is payable; and
- (b) a further 6 months for half the full amount of the sum the PCT initially determined was payable.

***Payment arrangements***

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

***Conditions attached to the amounts payable***

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

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

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

- (e) if the locum arrangements are in respect of a performer on leave who is or was entitled to statutory sick pay, the contractor must inform the PCT immediately if it stops paying statutory sick pay to that employee;

- (f) the performer on leave must not engage in conduct that is prejudicial to his recovery; and
- (g) the performer on leave must not be performing clinical services for any other person, unless under medical direction and with the approval of the PCT.

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

## **11. Payments for locums to cover for suspended doctors**

11.1 PCTs have powers to suspend GP performers from their medical performers list. They may also, on 1st April 2004, still be considering cases of GP performers who are on but suspended from their medical performers lists because prior to 1st April 2004 they were suspended from a medical list, a services list or a supplementary list.

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

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

may be entitled to payments directly from the PCT that suspended him. This is covered by a separate determination under regulation 13(17) of the Performers List Regulations.

### ***Eligible cases***

11.3 In any case where a contractor–

- (a) either–
  - (i) is a sole practitioner who is suspended from his PCT's medical performers list and is not in receipt of any financial assistance from his PCT under section 28Y of the 1977 Act as a contribution towards the cost of the arrangements to provide primary medical services under his GMS contract during his suspension,
  - (ii) is paying a suspended GP performer–
    - (aa) who is a partner in the contractor, at least 90% of his normal monthly drawings (or a *pro rata* amount in the case of part months) from the partnership account, or

- (bb) who is an employee of the contractor, at least 90% of his normal salary (or a *pro rata* amount in the case of part months), or
- (iii) paid a suspended GP performer the amount mentioned in paragraph (ii)(aa) or (bb) for at least six months of his suspension, and the suspended GP performer is still a partner in or employee of the contractor;
- (b) actually and necessarily engages a locum (or more than one such person) to cover for the absence of the suspended GP performer;
- (c) the locum is not a partner or shareholder in the contractor, or already an employee of the contractor, unless the absent performer is a job-sharer; and
- (d) the contractor is not also claiming a payment for locum cover in respect of the absent performer under another Section in this Part,

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

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

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

#### ***Ceilings on the amounts payable***

11.5 The maximum amount payable under this Section by the PCT in respect of locum cover for a GP performer is £948.33 per week.

#### ***Payment arrangements***

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

***Conditions attached to the amounts payable***

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

- (a) the contractor must, on request, provide the PCT with written records demonstrating–
  - (i) the actual cost to it of the locum cover, and
  - (ii) that it is continuing to pay the suspended GP performer the full amount of the income to which he was entitled before the suspension (i.e. his normal drawings from the partnership account or his normal salary); and
- (b) once the locum arrangements are in place, the contractor must inform the PCT–
  - (i) if there is to be any change to the locum arrangements, or
  - (ii) if, for any other reason, there is to be a change to the contractor’s arrangements for performing the duties of the absent performer,

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

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

## **12. Payments in respect of Prolonged Study Leave**

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

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

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

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

- (a) the study leave is for at least 10 weeks but not more than 12 months;
- (b) the educational aspects of the study leave have been approved by the local Director of Postgraduate GP Education, having regard to any guidance on Prolonged Study Leave that Directors of Postgraduate GP Education have agreed nationally; and
- (c) the PCT has determined that the payments to the contractor under this Section in respect of the Prolonged Study Leave are affordable, having regard to the budgetary targets it has set for itself for the financial year 2004 to 2005.

***The educational allowance payment***

12.3 Where the criteria set out in paragraph 12.2 are met, in respect of each week for which the GP performer is on Prolonged Study Leave, the PCT must pay the contractor an Educational Allowance Payment of £129.50 per week, subject to the condition that where the contractor is aware of any change in circumstances that may affect its entitlement to the Educational Allowance Payment, it notifies the PCT of that change in circumstances.

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

***Locum cover in respect of doctors on Prolonged Study Leave***

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

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

- (a) it should not normally be considered necessary to employ a locum if the PCT has offered to provide the locum cover itself and the contractor has refused that offer without good reason;
- (b) it should not normally be considered necessary to employ a locum if the performer on leave had a right to return but that right has been extinguished; and

- (c) it should not normally be considered necessary to employ a locum if the contractor has engaged a new employee or partner to perform the duties of the performer on leave and it is not carrying a vacancy in respect of another position which the performer on leave will fill on his return.

12.7 The maximum amount payable under this Section by the PCT in respect of locum cover for a GP performer is £948.33 per week.

***Payment arrangements***

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

***Conditions attached to the amounts payable***

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

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

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

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

## **13. Seniority payments**

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

### ***Eligible posts***

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

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

### ***Service that is Reckonable Service***

13.3 Work shall be counted as Reckonable Service if–

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

if accepted by the PCT or endorsed by the Secretary of State for Health as Reckonable Service;

- (d) it is service with the Foreign and Commonwealth Office as a medical officer in a diplomatic mission abroad, if accepted by the PCT or endorsed by the Secretary of State for Health as Reckonable Service; or
- (e) it is clinical service outside the United Kingdom that, prior to 1st April 2004, was counted as Reckonable Service for the purposes of a seniority payment under the Red Book.

### ***Calculation of years of Reckonable Service***

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

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

- (a) only clinical service is to count towards Reckonable Service;
- (b) only clinical service since the date on which the GP provider first became registered (be it temporarily, provisionally, fully or with limited registration) with the General Medical Council, or an equivalent authority in another EEA Member State, is to count towards Reckonable Service, with the exception of Reckonable Service prior to registration that is taken into account by virtue of paragraph 13.3(e);
- (c) periods of part-time and full-time working count the same; and
- (d) generally, breaks in service are not to count towards Reckonable Service, but periods when doctors were taking leave of absence (i.e. they were absent from a post but had a right of return) due to compulsory national service, maternity leave, paternity leave, adoption leave, parental leave, holiday leave, sick leave or study leave, or because of a secondment elective or similar temporary attachment to a post requiring the provision of clinical services, are to count towards Reckonable Service.

13.6 Claims in respect of service in or on behalf of armed forces pursuant to paragraph 13.3(c) are to be considered in the first instance by the PCT, and should be accompanied by appropriate details, including dates and relevant postings. If the PCT is not satisfied that the service should count towards the GP provider's Reckonable

Service as a doctor, it is to put the matter to the Secretary of State for Health, together with any comments it wishes to make.

13.7 Before taking his decision on whether or not to endorse the claim, the Secretary of State will then consult the Ministry of Defence. Generally, the only service that will be endorsed is service where the GP provider undertook clinical or medical duties (whether on military service or in a civilian capacity), and the Secretary of State has received acceptable confirmation of the nature and scope of the duties performed by the GP provider from the relevant authorities.

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

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

- (a) members of the Foreign and Commonwealth Office and their families;
- (b) members of the Overseas Development Administration and their families;
- (c) members of the British Council and their families;
- (d) British residents, official visitors and aid workers;
- (e) Commonwealth and EEA Member State official visitors; or
- (f) staff and their families of other Commonwealth, EEA Member State or friendly State diplomatic missions,

and the Secretary of State has received acceptable confirmation of the nature and scope of the clinical duties performed by the GP provider from the relevant authorities.

#### ***Determination of the relevant dates***

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

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

***Calculation of the full annual rate of Seniority Payments***

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

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

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

then add the totals produced by the calculations in heads (i) and (ii) together, and multiply by four.

**TABLE**

Years of Reckonable Service	Full annual rate of payment per practitioner in 2004-05
<b>0</b>	<b>0</b>
<b>1</b>	<b>0</b>
<b>2</b>	<b>0</b>
<b>3</b>	<b>0</b>
<b>4</b>	<b>0</b>
<b>5</b>	<b>0</b>

6	0
7	600
8	630
9	662
10	695
11	729
12	766
13	804
14	844
15	886
16	3,185
17	3,344
18	3,511
19	3,687
20	3,871
21	4,065
22	6,785
23	6,989
24	7,198
25	7,414
26	7,637
27	7,866
28	8,225
29	8,447
30	8,675
31	8,909
32	9,150
33	9,397
34	9,651
35	9,911
36	10,179
37	10,454
38	10,736
39	11,026
40	11,324
41	11,629
42	11,943
43	12,266
44	12,597
45	12,937
46	13,286
47	13,645

13.13 If, for any GP provider, the full annual rate payable in respect of him, as calculated above, is less than the total amount due to him—

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

that GP provider is entitled to at least that total amount as the full annual rate of his Seniority Payments in the financial year 2004 to 2005.

### ***Superannuable Income Fractions***

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

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

- (a) his NHS profits from all sources for the financial year 2004 to 2005, excluding—
  - (i) superannuable income which does not appear on his certificate submitted to the PCT in accordance with paragraph 22.10 (i.e. NHS income already superannuated elsewhere), and
  - (ii) any amount in respect of Seniority Payments; by
- (b) the Average Adjusted Superannuable Income.

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

- (a) all the NHS profits of the type mentioned in paragraph 13.15(a) of all the GP providers in England who have submitted certificates to a PCT in accordance with paragraph 22.10 by [a date still to be fixed] are to be aggregated; then
- (b) this aggregate is then to be divided by the number of GP providers in respect of which the aggregate was calculated; then
- (c) the total produced by sub-paragraph (b) is to be adjusted to take account of the shift towards less than full-time working. The index by which the amount is to be adjusted is to be the same as the index for the financial year 2004 to 2005 by which the uprating factor for pensions is to be adjusted to take account of the shift towards less than full-time working,

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

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

### ***Amounts payable***

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

13.19 If, however, the GP provider's—

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

13.20 Payment of the Quarterly Seniority Payment is to fall due on the last day of the quarter to which it relates (but see paragraph 21.8).

***Conditions attached to payment of Quarterly Seniority Payments***

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

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

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

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

## **14. Golden Hello Scheme**

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

### *Standard payments under the Golden Hello Scheme*

14.2 A doctor will be eligible for a standard payment under the Golden Hello Scheme if, after 1st April 2004, he takes up a post as a GP performer and—

- (a) the post is as a GP performer employed or engaged by a contractor (including a member of the Flexible Careers Scheme);
- (b) the post, if part-time—
  - (i) involves a working commitment that generates a Time Commitment Fraction of at least one fifth, or
  - (ii) with any other post held by the doctor that also entails performing primary medical services together involve working commitment that generates a Time Commitment Fraction of at least one fifth;
- (c) if the doctor is an employee of the contractor, he is on a contract—
  - (i) for an indefinite period (but not a fixed number of sessions), or
  - (ii) for a fixed term of more than two years,

unless he is a member of the Flexible Careers Scheme and he has given the PCT a written undertaking that he will remain in general practice at the end of his membership of the Flexible Careers Scheme;

- (d) subject to paragraph 14.3, prior to starting work in that post, he has not—

- (i) been included in the medical performers list, services list or medical list of any Health Authority or PCT (unless this was because of temporary arrangements made by a PCT for the provision of general medical services or the performance of primary medical services following the suspension of a doctor),
- (ii) been employed or engaged (except as a locum) by a GP principal to assist, as a medical practitioner, in the provision of general medical services, or worked (except as a locum) as a GP performer–
  - (aa) either full-time, or part-time with a working commitment generating a Time Commitment Fraction of at least one quarter, if he took up post before 29th November 2002, or at least one fifth if he took up post on or after 29th November 2002, and
  - (bb) under a contract for an indefinite period (but not for a fixed number of sessions) or for a fixed term of more than two years, or
- (iii) been engaged (except as a locum) as a pilot scheme provider or an employee of a pilot scheme provider, or worked (except as a locum) as a medical practitioner performing primary medical services under a PMS contract–
  - (aa) either full-time, or part-time with a working commitment generating a Time Commitment Fraction of at least one quarter, if he took up the post before 29th November 2002 or at least one fifth, if he took up the post on or after 29th November 2002, and
  - (bb) under a contract for an indefinite period (but not for a fixed number of sessions) or for a fixed term of more than two years,

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

- (e) subject to the provisions in this Section for making further payments because of new commitments, he has not previously received a standard payment under–
  - (i) this Section,
  - (ii) paragraph 38 of the Red Book,
  - (iii) the Golden Hello Scheme under a PMS contract,

- (iv) Schedule 1 to the New Entrant, Delayed Retirement and Flexible Careers Schemes (Personal Medical Services) (England) Directions 2003, or
- (v) Part 2 of the Personal Medical Services Contracts (Payments for Specific Purposes) Directions 2004.

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

***Additional payments under the Golden Hello Scheme***

14.4 If–

- (a) a doctor is eligible for a standard payment under paragraph 14.2; and
- (b) the post to which his claim pursuant to this Section relates was with a contractor whose sole or main surgery is, when he takes up the post, within the area of a PCT included in Annex H,

the doctor is potentially eligible for an additional payment under the Golden Hello Scheme. To be eligible for such a payment, the doctor’s working commitment to the post to which the claim for an additional payment relates must generate a Time Commitment Fraction of at least one fifth.

***Calculation of standard and additional payments under the Golden Hello Scheme***

14.5 Subject to the following provisions of this Section, PCTs must pay to contractors, in respect of doctors –

- (a) who are eligible for standard or additional payments under the Golden Hello Scheme, and
- (b) whose eligibility arises because of a work commitment that relates to the primary medical services that the contractor has undertaken to provide under its GMS contract,

any standard or additional payment for which that doctor is eligible, and at the following rates–

<i>Standard Payment</i>	
Full-time, or part-time with a Time Commitment Fraction of at least ½	£5,000
Part-time with a Time Commitment Fraction of less than ½	£3,000
<i>Additional payment</i>	
Full-time, or part-time with a Time Commitment Fraction of at least ½	£7,000
Part-time with a Time Commitment Fraction of less than ½	£4,200

### *Further payments for new commitments*

14.6 If, under the Golden Hello Scheme (whether under this Section or the other provisions listed in paragraph 14.2(e)), the lower level of the standard payment has been paid to or in respect of a doctor, or a standard payment was made to or in respect of the doctor but either no additional payment or the lower level of the additional payment was paid, the contractor may be entitled to a further payment from the PCT under his GMS contract if, after 1st April 2004, the doctor's work commitment changes, and–

- (a) this is within two years of the doctor taking up the post that made him eligible for a standard payment under the Golden Hello Scheme (“the eligible post”); or
- (b) the doctor took up the post that made him eligible for the standard payment while he was a member of the Flexible Careers Scheme, and the change to his work commitment is within two years of leaving that Scheme.

14.7 In these circumstances, if–

- (a) the doctor increases his time commitment to the contractor, whether in the eligible post or by moving to a new post or by taking on an additional post; or
- (b) with or without an increased time commitment, the doctor moves from a post that did not attract an additional payment to a post that would (for a new entrant) attract an additional payment,

he will be eligible for the further payments set out in paragraphs 14.8 and 14.9.

14.8 In a case where the doctor increases his time commitment–

- (a) if work relating to the new time commitment starts–
  - (i) within six months of the doctor taking up the eligible post, or
  - (ii) as regards a doctor who is in or has left the Flexible Careers Scheme, within two years of him leaving that Scheme,

the further payment for which he is eligible is the difference between the standard (and where applicable additional) payment the doctor would have received if the new time commitment had been the doctor's time commitment when he first took up the eligible post and the standard (and where applicable additional) payment already awarded to him under the Golden Hello Scheme; or

- (b) if–

- (i) work relating to the new time commitment starts within two years of the doctor taking up the eligible post, but more than six months after he took up the post, and
- (ii) the doctor is not and has not been in the Flexible Careers Scheme,

the further payment for which he is eligible is half the difference between the standard (and where applicable additional) payment the doctor would have received if the new time commitment had been the doctor's time commitment when he first took up the eligible post and the standard (and where applicable additional) payment already awarded to him under the Golden Hello Scheme.

14.9 In a case where the doctor—

- (a) moves from a post that did not attract an additional payment to a post that would (for a new entrant) attract an additional payment; or
- (b) takes on an extra post that would (for a new entrant) attract an additional payment,

the further payment is to be the additional payment that the doctor would have received if the new work commitment (also taking into account any additional time commitment) had been the doctor's work commitment when he first took up the eligible post.

14.10 Subject to the following provisions of this Section, PCTs must pay to contractors, in respect of doctors—

- (a) who are eligible for further payments under the Golden Hello Scheme, pursuant to paragraphs 14.6 to 14.9, and
- (b) whose eligibility arises because of a work commitment that relates to the primary medical services that the contractor has undertaken to perform under its GMS contract,

any further payment for which that doctor is eligible.

***Conditions attached to payments under the Golden Hello Scheme***

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

- (a) applications for standard, additional and further payments under the Golden Hello Scheme must be made—
  - (i) in the case of standard or additional payments, within 12 months of the date on which the doctor took up the eligible post,

- (ii) in the case of an additional payment, within 12 months of the date on which the new work commitment starts;
- (b) a contractor who receives a payment under the Golden Hello Scheme in respect of a doctor must give that payment to that doctor–
  - (i) within one calendar month of it receiving that payment, and
  - (ii) as an element of the personal income of that doctor, subject to any lawful deduction of income tax, national insurance and superannuation contributions,

once it has secured from the doctor an enforceable undertaking that he will repay to the contractor any amount repayable by the contractor to the PCT under this Section in respect of him;

- (c) if, within two years of starting in an eligible post giving rise to a standard payment (and any related additional payment) under this Section, the doctor in respect of whom the payment was made ceases to practise as a medical practitioner anywhere in the United Kingdom, the contractor that received the standard payment (and any related additional payment) must repay to the PCT–
  - (i) the whole of the standard payment (and any related additional payment) paid to the contractor, if the doctor ceases to practise within 6 months of him starting in the eligible post, or
  - (ii) half the standard payment (taken together with any related additional payment) paid to the contractor, if the doctor ceases to practise within two years of him starting in the eligible post but more than six months after him starting in that post;
- (d) if within two years of starting in an eligible post giving rise to an additional payment (or a further payment in place of an additional payment) under this Section, the doctor in respect of whom the payment is made ceases to practise as a medical practitioner anywhere in the United Kingdom or moves to a post which would not, for a new entrant, attract an additional payment, the contractor that received the additional payment (or further payment in place of an additional payment) must repay to the PCT–
  - (i) the whole of the additional payment (or further payment) paid to the contractor, if the move takes place or the doctor ceases to practise within 6 months of the doctor starting in the post that gave rise to the payment, or
  - (ii) half of the additional payment (or further payment), if the move takes place or the doctor ceases to practise within two years of

him starting in the post that gave rise to the payment but more than six months after him starting in that post.

14.12 For the purposes of calculating the time periods referred to in paragraph 14.11(c) and (d), the following periods are discounted–

- (a) periods of maternity, paternity, adoption or parental leave, if the doctor–
  - (i) in the case of–
    - (aa) ordinary or additional maternity, paternity or adoption leave, gives an undertaking that he will return to general practice after not more than two years' absence, or
    - (bb) extended maternity, paternity or adoption leave, or parental leave, agrees the leave with the PCT and undertakes to return to general practice at the end of the agreed period of leave, and
  - (ii) honours that undertaking;
- (b) periods of absence due to exceptional personal circumstances known to and endorsed by the PCT.

14.13 If the condition in paragraph 14.11(a) is breached, the payment to which the application relates is not payable.

14.14 If the condition in paragraph 14.11(b) is breached, the PCT may require repayment of the payment paid to the contractor, or may withhold payment of any other payment payable to the contractor under this SFE, to the value of the payment paid.

14.15 If the conditions in paragraph 14.11(c) and (d) are breached because the doctor ceases to practise because of–

- (a) death; or
- (b) forced early retirement because of illness or injury,

then no amount is repayable, but otherwise, the PCT may require repayment of the payment paid, or the excess amount paid, or may withhold payment of any other payment payable to the contractor under this SFE, to the value of the payment or excess amount paid.

14.16 Where, pursuant to paragraph 14.14, a contractor is required to repay any or any part of a standard, additional or further payment under this Section, the arrangements by which the contractor may seek to enforce the undertaking referred to in paragraph 14.11(b) as a consequence of that repayment are a matter for the contractor.

## **15. Returners' Scheme**

15.1 This is an established Scheme designed to facilitate the return of qualified GPs to the NHS. It is managed locally by Postgraduate Deaneries, each of which has a local Return Co-ordinator responsible for admitting doctors to the Scheme.

### ***Returners' Scheme Doctor Payments***

15.2 If a GP performer has been employed or engaged by a contractor, and that GP performer is a doctor who is a member of the Returners' Scheme (RS), the PCT must, in respect of that doctor, pay to the contractor an annual RS Doctor Payment of £1,050.

15.3 If–

- (a) a RS doctor's membership of the RS ceases during a year of membership; or
- (b) a RS doctor moves to new employer during a year of membership of the RS, or becomes a partner or shareholder in a different contractor, but remains a member,

the amount of the RS Doctor Payment payable to the contractor is to be adjusted as follows. Multiply the amount of the payment otherwise payable by the following fraction: the number of days for which the RS doctor is contracted to work for the contractor during the membership year, divided by 365.

15.4 Payments under this Section to the contractor are to fall due–

- (a) if the doctor joins the RS on or after 1st April 2004 on the last day of the month during which the date on which he joins the scheme falls; and
- (b) if the doctor joined the RS before 1st April 2004, on the last day of the month during which the anniversary of the date on which he joined the scheme falls.

### ***Conditions attached to Returners' Scheme Doctor Payments and overpayments***

15.5 RS Doctor Payments, or any part thereof, are only payable if the following conditions are satisfied–

- (a) a contractor who receives a RS Doctor Payment in respect of a GP performer must give that payment to that GP performer–
  - (i) within one calendar month of it receiving that payment, and

- (ii) as an element of the personal income of that doctor, subject to any lawful deduction of income tax, national insurance and superannuation contributions,

once it has secured from the doctor an enforceable undertaking that he will repay to the contractor any amount repayable by the contractor to the PCT under this Section in respect of him;

- (b) the contractor must inform the PCT if the GP performer in respect of whom the payment is made ceases to be a member of the RS.

15.6 If a contractor breaches these conditions, the PCT may require repayment of the payment paid, or may withhold payment of any other payment payable to the contractor under this SFE, to the value of the payment paid.

15.7 If as a result of a doctor leaving the RS, the PCT has paid a larger amount to the contractor in respect of that doctor's RS Doctor Payment than the amount to which the contractor is entitled under this Section, the PCT may require repayment of the excess paid, or may withhold payment of any other payment payable to the contractor under this SFE, to the value of the excess paid.

15.8 Where, pursuant to paragraph 15.6 or 15.7, a contractor is required to repay any or any part of a RS Doctor Payment, the arrangements by which the contractor may seek to enforce the undertaking referred to in paragraph 15.5(a) as a consequence of that repayment are a matter for the contractor.

## **16. Flexible Careers Scheme**

16.1 This is an established Scheme for certain part-time doctors. It is managed locally by Postgraduate Deaneries and is for employed doctors only. Contractors are eligible for contractor payments under this Scheme, but will also receive payments to be forwarded to doctors.

### ***Flexible Careers Scheme Contractor Payments***

16.2 A PCT must pay to a contractor under its GMS contract a Flexible Career Scheme (FCS) Contractor Payment if–

- (a) it employs a part-time doctor who is a member of the FCS; and
- (b) that FCS doctor performs primary medical services under its GMS contract, as a medical practitioner, with a working commitment that generates a Time Commitment Fraction of at least one fifth but not more than five ninths, except that the doctor may also work–
  - (i) an additional 28 hours, during the membership year, of funded education time for personal and professional development, and

- (ii) a limited amount of additional time in the National Health Service, with the approval of his local Director of Postgraduate GP Education.

16.3 For the purposes of the calculation of time commitment in paragraph 16.2(b), the following periods of leave are discounted–

- (a) annual leave up to a maximum of six weeks *pro rata* (compared to full-time);
- (b) maternity, paternity, parental or adoption leave endorsed by the PCT;
- (c) sickness leave endorsed by the PCT;
- (d) special leave in an emergency, which is granted in accordance with employment law and guidance issued by the Department of Trade and Industry; and
- (e) other special leave for pressing personal or family reasons, endorsed by the PCT.

***Amount of FCS Contractor Payments***

16.4 PCTs will need to obtain from the contractor at the end of each quarter a return of the actual cost to the contractor, rounded to the nearest pound, of it employing the FCS doctor while he is a member of the scheme. This is–

- (a) to include salary, national insurance contributions and NHS pension scheme contributions;
- (b) not to include costs relating to any additional work the FCS doctor is permitted, with the approval of his local Director of Postgraduate GP Education, to undertake outside the FCS.

16.5 A percentage of that amount is then payable as the contractor’s FCS Contractor Payment, as calculated (subject to the following provisions of this Section) in accordance with the following table–

**TABLE**

*In respect of doctors whose applications to join the FCS have been received by their local Director of Postgraduate GP Education before 1st January 2004 and who join the scheme before 1st April 2004*

Year 1	50%
Year 2	50%
Year 3	25%
Year 4	10%

*In respect of other FCS doctors*

Year 1	50%
Year 2	25%
Year 3	10%

16.6 For these purposes–

- (a) the qualifying date for the first payment, and so the start of the doctor’s first year in the Scheme, is the date the doctor joins the Scheme;
- (b) if, in relation to any period of leave referred to in paragraph 16.3 the local Director of Postgraduate GP Education reasonably determines that, for exceptional reasons, the year of membership of the FCS in which the period of leave started should be extended, that year of membership shall not be taken to have elapsed until a full year has elapsed from the start of that year of membership, discounting the period of leave, and his qualifying date for payments must be adjusted accordingly; and
- (c) if the quarterly return relates to costs incurred in respect of different years of membership of the FCS, the contractor must specify which costs relate to which year of membership of the scheme.

***Amount of FCS Doctor Payments***

16.7 Subject to the following provisions of this Section, if a contractor is eligible for a FCS contractor payment, the PCT must also pay to the contractor under its GMS contract, in respect of the doctor who is a member of the FCS, an annual FCS Doctor Payment of £1,050.

***Payments in respect of part years***

16.8 If–

- (a) an FCS doctor’s membership of the FCS ceases during a year of membership; or
- (b) an FCS doctor moves to new employer during a year of membership of the FCS but remains a member of the scheme,

the amount of the FCS Doctor Payment payable to the contractor is to be adjusted by multiplying the amount of the payment otherwise payable by the following fraction: the number of days for which the FCS doctor is contracted to work for the contractor during the membership year, divided by 365.

***Payments in respect of educational sessions***

16.9 In respect of each of up to eight educational sessions attended in a year of membership of the FCS by an FCS doctor, and on the basis of a return from the contractor at the end of each quarter, the PCT must reimburse the contractor who employs the FCS doctor under its GMS contract for–

- (a) the actual cost of employing the FCS doctor during those sessions (to be determined in accordance with paragraph 16.5 above); and
- (b) any expenses claimed by and paid to the FCS doctor by the contractor to cover the cost of his actual travel and subsistence in attending those sessions, if these costs are reasonable in the opinion of the PCT.

***Payment arrangements***

16.10 FCS Doctor Payments to the contractor are to fall due on the last day of the month during which his qualifying date falls, taking account of any adjustment of his qualifying date in accordance with paragraph 16.6.

16.11 The other payments under this Section are to fall due on the last day of the month following the quarter in respect of the quarterly return is made.

***Conditions attached to Flexible Career Scheme payments and overpayments***

16.12 FCS Contractor Payments and payments under paragraph 16.9(a), or any part thereof, are only payable if the contractor satisfies the following conditions–

- (a) the contractor must make available to the PCT any information which the PCT does not have but needs, and the contractor either has or could reasonably be expected to obtain, in order to calculate the payment. In particular, the contractor must, on request, provide the PCT with written records demonstrating the actual costs it is seeking to recover; and
- (b) all information supplied pursuant to or in accordance with this paragraph must be accurate.

16.13 FCS Doctor Payments, or any part thereof, are only payable if the following conditions are satisfied–

- (a) a contractor that receives an FCS Doctor Payment in respect of a doctor must give that payment to that doctor–
  - (i) within one calendar month of it receiving that payment, and
  - (ii) as an element of the personal income of that doctor, subject to any lawful deduction of income tax, national insurance and superannuation contributions,

once it has secured from the doctor an enforceable undertaking that he will repay to the contractor any amount repayable by the contractor to the PCT under this Section in respect of him;

- (b) the contractor must inform the PCT if the doctor in respect of whom the payment is made ceases to be a member of the FCS.

16.14 Payments in respect of expenses under paragraph 16.9(b) are only payable if the following conditions are satisfied—

- (a) the contractor must make available to the PCT any information which the PCT does not have but needs (including receipts), and the contractor either has or could reasonably be expected to obtain in order to calculate the payment; and
- (b) all information provided pursuant to or in accordance with subparagraph (a) must be accurate.

16.15 If a contractor breaches the conditions set out in paragraph 16.12 or 16.14, the PCT may in appropriate circumstances withhold payment of any or any part of a payment to which the conditions relate that is otherwise payable.

16.16 If a contractor breaches the conditions in paragraph 16.13, the PCT may require repayment of any payment paid to which the condition relates, or may withhold payment of any other sum payable to the contractor under this SFE, to the value of the payment paid.

16.17 If as a result of the doctor leaving the FCS, the PCT has paid a larger amount to the contractor in respect of a FCS Doctor Payment than the amount to which the contractor is entitled, the PCT may require repayment of the excess paid, or may withhold payment of any other sum payable to the contractor under this SFE, to the value of the excess paid.

16.18 Where, pursuant to paragraph 16.16 or 16.17, a contractor is required to repay any or any part of a RS Doctor Payment, the arrangements by which the contractor may seek to enforce the undertaking referred to in paragraph 16.13(a) as a consequence of that repayment are a matter for the contractor.

## **17. Doctors' Retainer Scheme**

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

### ***Payments in respect of sessions undertaken by members of the Scheme***

17.2 Where—

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

the PCT must pay to that contractor under its GMS contract £57.33 in respect of each full session that the member of the Doctors' Retainer Scheme undertakes for the contractor in any week, up to a maximum of four sessions per week.

### ***Payment conditions***

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

- (a) the contractor must inform the PCT of any change to the member of the Doctors' Retainer Scheme's working arrangements that may affect the contractor's entitlement to a payment under this section; and
- (b) the contractor must inform the PCT if the doctor in respect of whom the payment is made ceases to be a member of the Doctors' Retainer Scheme, or if it ceases to be considered a suitable employer of members of the Doctors' Retainer Scheme by the Regional Dean.

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

## **18. Dispensing**

18.1 Some contractors are authorised or required to provide dispensing services to specific patients. The arrangements for this are set out in Part 3 of Schedule 6 to the 2004 Regulations.

### ***Costs in respect of which reimbursement is payable***

18.2 Where drugs and appliances are provided by a medical practitioner—

- (a) in accordance with the terms relating to the provision of dispensing services set out in paragraph 50 in Part 3 of Schedule 6 to the 2004 Regulations (or related transitional arrangements); or
- (b) either for immediate treatment or for personal administration, in accordance with paragraph 52 in Part 3 of Schedule 6 to the 2004 Regulations,

then subject to the following provisions of this Section, the PCT must pay to the contractor under its GMS contract the payments listed in paragraph 18.3, as calculated in accordance with this Section.

18.3 The payable payments in relation to the provision of drugs and appliances are—

- (a) the basic price of the drug or appliance, which is the price as defined in Part II, Clauses 8 and 11, of the Drug Tariff, less a discount calculated in accordance with Part 1 of Annex I;
- (b) an on-cost allowance of 10.5% of the basic price of the drug or appliance before the deduction of the discount referred to in sub-paragraph (a);
- (c) a container allowance of 3.8p per prescription;
- (d) the appropriate dispensing fee, as set out in Part 2 of Annex I (in respect of contractors authorised or required to provide dispensing services in accordance with Part 3 of Schedule 6 to the 2004 Regulations) or Part 3 of Annex I (in respect of all other contractors);
- (e) unless the contractor is registered with Customs and Excise for VAT purposes, an allowance to cover the VAT payable on the purchase of drugs, appliances and containers. The allowance is to be calculated as a percentage of—
  - (i) the basic price of the drug or appliance before the deduction of the discount referred to in sub-paragraph (a), and
  - (ii) the container allowance referred to in sub-paragraph (c),and for these purposes, the rate payable shall be equivalent to the percentage rate of VAT in force on the first day of the quarter in which the items were dispensed; and
- (f) exceptional expenses, as provided for in Part II, clause 12, of the Drug Tariff.

***Personally administered drugs and appliances, and those used for diagnosis***

18.4 A contractor who is providing services under a GMS contract may, whether or not the contractor is authorised or required to provide dispensing services to specific patients, be entitled to the payments listed in paragraph 18.3. This applies only in relation to the following products—

- (a) vaccines, anaesthetics and injections;
- (b) the following diagnostic reagents: Dick Test; Schick Test; Protein Sensitisation Test Solutions; and Tuberculin Tests (i.e. Koch Test, Mantoux Test, Patch Test and Diagnostic Jelly);

- (c) intrauterine contraceptive devices (including drug-releasing IUCDs, contraceptive caps and diaphragms);
- (d) pessaries which are appliances; and
- (e) sutures (including skin closure strips).

18.5 In respect of these products, subject to the provisions of this Section, the PCT must pay to all contractors under their GMS contracts the payments listed in paragraph 18.3, as calculated in accordance with this Section – if the products are provided in accordance with paragraph 52(1)(a) or (b) in Part 3 of Schedule 6 to the 2004 Regulations.

***Products not covered by this Section***

18.6 No payments are payable under this Section in respect of the following products (which are centrally supplied vaccines): HiB (Haemophilus influenzae type B); MMR (Measles, Mumps and Rubella); BCG (Bacillus Calmette-Guérin); Diphtheria Vaccine Adsorbed (Child); Low dose Diphtheria vaccine for adults (adsorbed); D/T (Diphtheria/Tetanus); D/T/P (Diphtheria/Tetanus/ Pertussis); D/T/P-HiB (Diphtheria/Tetanus/Pertussis and Haemophilus influenzae type B combined product for administration as one injection); Td ampoule presentation (Tetanus combined with Diphtheria Vaccine for adults); Pertussis; oral Polio; inactivated Polio; Tuberculin Purified Protein Derivative; Meningococcal C conjugate vaccine (for children under 5 and persons entering the first year of higher education); and Meningococcal A& C polysaccharide vaccine (for persons entering the first year of higher education).

18.7 If a medical practitioner issues a prescription for a drug or appliance instead of supplying it himself, no payments are payable in respect of that drug or appliance under this Section.

***Oxygen and oxygen therapy equipment***

18.8 The payments listed in paragraph 18.3 do not apply in respect of the supply of oxygen and oxygen therapy equipment. These are covered by separate arrangements set out in Part 4 of Annex I.

***Deductions in respect of charges***

18.9 Payment in respect of prescriptions shall be subject to any deduction required to be made under the National Health Service (Charges for Drugs and Appliances) Regulations 2000<sup>1</sup> in respect of charges required to be made and recovered by the dispensing practitioner.

***Contractors unable to obtain discounts***

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<sup>1</sup> S.I. 2000620 as amended by 2000/122, 2001/746 and 2887, 2002/548 and 2352 and 2003/699, 585, 1084 and 3189.

18.10 If a contractor satisfies the PCT that, by reason of the remoteness of the contractor's practice premises, the contractor is unable to obtain any discount on the basic price of drugs and appliances for which a payment is payable by the PCT under this section (and the PCT must consult the Local Medical Committee, if there is one, before being so satisfied), the PCT must approve an exemption for that contractor from the application of the discount scale. The exemption shall be granted for a period of up to one year, and may be renewed thereafter for further periods, each not exceeding one year, if the contractor is able to satisfy the PCT that it is still unable to obtain any discount on the basic price of drugs and appliances for which a payment is payable under this section.

18.11 Where a PCT approves such an exemption, it must inform the Prescription Pricing Authority (PPA) of the exemption and of the period for which it is to apply.

***Contractors that are to receive special payments***

18.12 If a contractor satisfies the PCT that –

- (a) by reason of the remoteness of the contractor's practice premises or the small quantities of drugs and appliances that the contractor needs to buy, the contractor has had to pay more than the basic price for drugs and appliances it orders; and
- (b) its payments under paragraph 18.3(a) should be calculated at special payment levels rather than basic price levels,

(and the PCT must consult the Local Medical Committee, if there is one, before being so satisfied), the PCT must agree reimburse the contractor on the basis of the special payment levels, instead of the basic price levels, of the drugs and appliances it supplies, as set out in the table below–

<i>Where on average the price paid by the contractor (excluding VAT) has been:</i>	<i>Special payment price level</i>
in excess of 5% and up to 10% over the basic price	5% over the basic price
in excess of 10% and up to 15% over the basic price	10% over the basic price
in excess of 15% and up to 20% over the basic price	15% over the basic price
in excess of 20% over the basic price	20% over the basic price

18.13 However–

- (a) the VAT allowance (see paragraph 18.3(f)) shall be calculated on the basis of the basic price; and

- (b) the on-cost allowance (see paragraph 18.3(b)) shall be calculated on the basis of the basic price (with no discount deducted).

18.14 Agreement to reimburse on the basis of special payment levels shall be granted for a period of up to one year, and may be renewed thereafter if the contractor is still able to satisfy the PCT that its payments under paragraph 18.3(a) should be calculated at special payments levels rather than basic price levels.

***Preconditions before payments under this Section are payable***

18.15 The payments listed in paragraph 18.3 are only payable if the contractor has–

- (a) noted, counted and sent all the prescriptions in respect of drugs or appliances in respect of which it wishes to claim reimbursement to the PPA, Bridge House, 152 Pilgrim Street, Newcastle-upon-Tyne, NE1 6SN, not later than the 5th of the month following the month to which the prescriptions relate; and
- (b) included all the claims under cover of a single claim form, and divided all the prescriptions into two bundles (for the calculation of the dispensing fee), and–
  - (i) one of these two bundles must be of prescription forms in respect of which no charge is payable, because–
    - (aa) the patient is entitled to an exemption,
    - (bb) the drugs or appliances were no-charge contraceptives, or
    - (cc) the drugs or appliances were personally administered items, and are in the list in paragraph 18.4, and
  - (ii) the other of these two bundles must be of prescription forms in respect of which a charge is payable, whether or not the charge has been collected (if the prescription form is for more than one item, at least one of which is chargeable, it should be included in this bundle),

and if the claim is in respect of the following high-volume personally administered vaccines – influenza, typhoid, hepatitis A, hepatitis B, Pneumococcal, and Meningococcal – it must be made in the form of bulk entries on the claim form.

***Payment arrangements***

18.16 Where a contractor has satisfied the conditions in paragraph 18.15, the PCT must pay to the contractor under its GMS contract–

- (a) on the first day of the month after the month on which the contractor submitted its claim to the PPA, an amount that represents 80% of the

amount that the PCT reasonably estimates is likely to be due to the contractor in respect of the claim, once the PPA has certified the amount due in respect of the claim (having taken into account the charges that are required to be made and recovered), although the PCT may pay less than 80% if the contractor's claims each month in respect of prescriptions vary significantly; and

- (b) on the first day of the second month after the month on which the contractor submitted its claim to the PPA, the balance of the amount due in respect of the claim, having had that amount certified by the PPA, and taking into account–
  - (i) the charges that are required to be made and recovered, and
  - (ii) the amount already paid out in respect of the claim pursuant to sub-paragraph (a).

***Accounting obligations***

18.17 It is a condition of the payments payable under this section that the payments are only payable under this section if the contractor ensures that–

- (a) its actual expenditure on drugs and appliances (i.e. the amount it pays its suppliers) is shown “gross” on its practice accounts, and
- (b) its payments from PCTs pursuant to this section, and collected from patients in accordance with the National Health Service (Charges for Drugs and Appliances) Regulations 2000, are brought “gross” into its contractor accounts as “income”.

## PART 5

### CERTAIN PREMISES AND I.T. COSTS

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

#### **19. Existing premises development and improvement commitments**

##### *Existing commitments*

19.1 Where PCTs have already committed themselves, prior to 1st April 2004, to provide financial assistance in the financial year 2004 to 2005–

- (a) towards the building of new premises to be used for providing medical services;
- (b) towards the purchase of premises to be used for providing medical services;
- (c) towards the development of premises which are used or are to be used for providing medical services; or
- (d) in the form of premises improvement grants,

in accordance with the arrangements for funding capital investment in premises set out in the Red Book, then subject to the provisions of this Section, those commitments are to be met.

19.2 As regards any such capital investment project, a PCT must pay to a contractor under its GMS contract any amount that the PCT agreed before 1st April 2004 to pay to the contractor (or to the practice for which the contractor is now responsible) during the financial year 2004 to 2005, subject to the following conditions–

- (a) the contractor must comply with any conditions to which the agreement to make the payment was subject. For these purposes, it shall be deemed that the specifications for the project which are set out in the project proposal, and any standards to be met during construction or development work which are set out in the project proposal, are all conditions of the agreement to make the payment; and

- (b) the project must not change significantly (in the PCT's view) from the version of the project in respect of which the PCT agreed to make the payments.

19.3 If any of these conditions are breached, the PCT may in appropriate circumstances withhold payment of any or any part of any payment that is otherwise payable under paragraph 19.2. If the breach arises because the project has changed significantly, and additional costs will be incurred as a consequence, any claim for PCT funding in respect of those additional costs is to be determined in accordance with the arrangements for funding new capital investment set out in the Primary Medical Services (Premises Costs) (England) Directions 2004.

19.4 If it was agreed before 1st April 2004 that the amount of payments payable in respect of the project plan would be reviewed in the financial year 2004 to 2005, the payments payable under this Section are subject to the outcome of that review and any revised amount agreed in accordance with that review becomes the amount payable under this Section. If a dispute as to the amounts payable arises as a result of that review, that dispute shall be resolved in accordance with–

- (a) any dispute resolution procedure (for resolution of disputes between the PCT and the contractor) agreed in respect of the project plan; or
- (b) if no such procedure was agreed, the NHS dispute resolution procedures – or by the courts (see Part 7 of Schedule 6 to the 2004 Regulations).

## **20. I.T. expenses**

20.1 With effect from 1st April 2003, PCTs, rather than contractors, have become responsible for the purchase, maintenance, future upgrades and running costs of integrated IM &T systems for providers of services under GMS contracts, as well as for telecommunications links within the NHS.

20.2 Pending the transfer of these responsibilities, PCTs must in respect of the financial year 2004 to 2005 pay to contractors under their GMS contracts amounts representing the reasonable costs of contractors in respect of IT maintenance and minor upgrades (i.e. where these costs are not met directly by the PCT). For these purposes–

- (a) “maintenance” means routine support that is normally provided under annual contracts by GP clinical system suppliers or third parties. For the purposes of determining whether maintenance costs are reasonable, PCTs should review and consolidate existing maintenance contracts to ensure that they represent value for money and provide the required levels of support; and
- (b) “minor upgrades” means upgrades required to ensure that existing clinical systems continue to perform efficiently (for example: memory

or hard disk upgrades, and replacement of broken or defective items such as printers, screens and back-up devices).

20.3 Payments under this Section are not to cover the cost of system replacements or significant upgrades (such as the purchase of new hardware, other than new hardware covered by paragraph 20.2(b)). Payment in respect of these items of expenditure is not covered in this SFE.

## **PART 6**

### **SUPPLEMENTARY PROVISIONS**

#### **21. Administrative Provisions**

##### *Overpayments*

21.1 Without prejudice to the specific provisions elsewhere in this SFE relating to overpayments of particular payments, if a PCT makes a payment to a contractor under its GMS contract pursuant to this SFE and—

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

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

##### *Underpayments and late payments*

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

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

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

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

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

21.4 However, if a contractor has—

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

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

21.5 Furthermore, for the first quarter to which this SFE relates, if a PCT is unable to calculate any payment payable pursuant to this SFE that falls due before the end of that quarter because it does not have the information or computer software it needs in order to calculate that payment (all reasonable efforts to obtain the information, or make the calculation, having been undertaken), that payment is instead to fall due at the end of that quarter.

### ***Payments on account***

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

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

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

21.7 However, during the first quarter to which this SFE relates, if–

- (a) a PCT is unable to calculate a payment payable pursuant to this SFE that is due to fall due before the end of that quarter because it does not have the information or computer software it needs in order to calculate that payment (all reasonable efforts to obtain the information, or calculate the payment, having been undertaken); and
- (b) it cannot reach agreement with the contractor on a payment on account in respect of the payment pursuant to paragraph 21.6,

it must nevertheless pay to the contractor on account a reasonable approximation of the amount of the payment, on or before the unrevised due date for payment of that payment (i.e. before it is revised in accordance with paragraph 21.5). If that payment results in an overpayment in respect of the payment, paragraph 21.1 applies.

21.8 PCTs will not be able to calculate the correct amount of GP providers' Seniority Payments during the financial year 2004 to 2005 because it will not be possible to calculate the correct value of the GP provider's Superannuable Income Fraction until–

- (a) the Average Adjusted Superannuable Income for the financial year 2004 to 2005 has been established; and
- (b) the GP provider's own NHS superannuable profits from all sources for the financial year 2004 to 2005, excluding–
  - (i) superannuable income which does not appear on his certificate submitted to the PCT in accordance with paragraph 22.10, and
  - (ii) any amount in respect of Seniority Payments,have been established.

If a PCT cannot reach agreement with a contractor on a payment on account in respect of a Quarterly Seniority Payment pursuant to paragraph 21.6, it must nevertheless pay to the contractor on account a reasonable approximation of the Quarterly Seniority Payment, on or before the unrevised due date for payment of that payment (i.e. before it is revised in accordance with paragraph 21.4). If that payment results in an overpayment in respect of the Quarterly Seniority Payment, paragraph 21.1 applies.

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

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

- (a) as a payment on account under the contractor's GMS contract pursuant to paragraph 21.6 or 21.7, it shall be treated as a payment on account

pursuant to paragraph 21.6 or 21.7 (and for these purposes a payment of one twelfth of a final global sum equivalent under a default contract or under article 41(1) of the 2004 Order shall be treated as a payment on account in respect of a Payable GSMP); and

- (b) as a payment under the contractor's GMS contract pursuant to Part 4 or 5 of this SFE, it shall be treated as a payment under the contractor's GMS contract pursuant to Part 4 or 5 of this SFE,

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

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

- (a) the GMS contract is agreed between 1st June 2004 and 1st September 2004, in which case they are instead to fall due at the end of the second quarter, as are all the payments that are or were due to fall due pursuant to this SFE in the second quarter;
- (b) the GMS contract is agreed between 1st September and 1st December 2004, in which case they are instead to fall due at the end of the third quarter, as are all the payments that are or were due to fall due pursuant to this SFE in that quarter or in the second quarter; or
- (c) the GMS contract is agreed between 1st December 2004 and the end of the financial year, in which case they are to fall due at the end of the financial year, as are all the other payments that are or were due to fall due pursuant to this SFE before the end of the financial year.

### **Payments to or in respect of suspended doctors whose suspension ceases**

21.11 If the suspension of a GP from a medical practitioners list ceases, and—

- (a) that GP enters into a GMS contract that takes effect for payment purposes on 1st April 2004, any payments that the GP received under a determination made under regulation 13(17) of the Performers List Regulations may be set off, equitably, against the payments that he is entitled to receive under his GMS contract pursuant to this SFE; or
- (b) a contractor is entitled to any payments in respect of that GP pursuant to this SFE and a payment was made to the GP pursuant to a determination made under regulation 13(17) of the Performers List Regulations but the GP was not entitled to receive all or any part thereof, the amount to which the GP was not entitled may be set off, equitably, against any payment in respect of him pursuant to this SFE.

### ***Effect on periodic payments of termination of a GMS contract***

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

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

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

#### ***Time limitation for claiming payments***

21.13 Payments under this SFE are only payable if claimed within six years of the date on which they could first have fallen due (albeit that the due date has changed pursuant to paragraph 21.4 or 21.5).

#### ***Dispute resolution procedures***

21.14 Any dispute arising out of or in connection with this SFE between a PCT and a contractor (except one to which paragraph 19.4(a) applies) is to be resolved as a dispute arising out of or in connection with the contractor's GMS contract, i.e. in accordance with the NHS dispute resolution procedures or by the courts (see Part 7 of Schedule 6 to the 2004 Regulations).

21.15 The procedures require the contractor and the PCT to make every reasonable effort to communicate and cooperate with each other with a view to resolving the dispute between themselves before referring it for determination. Either the contractor or the PCT may, if it wishes to do so, invite the Local Medical Committee to participate in these discussions.

#### ***Protocol in respect of locum cover payments***

21.16 Part 4 sets out a number of circumstances in which PCTs are obliged to pay a maximum amount of £948.33 for locum cover in respect of an absent performer. However, even where a PCT is not directed pursuant to this SFE to make payments in respect of such cover, it has powers to do so as a matter of discretion – and may also decide, as a matter of discretion, to make top-up payments in cases where the £948.33 maximum directed amount is payable.

21.17 As a supplementary measure, PCTs are directed to adopt a protocol, which they must take all reasonable steps to agree with any relevant Local Medical Committee, setting out in reasonable detail–

- (a) how they are likely to exercise their discretionary powers to make payments (including top-up payments) in respect of locum cover, having regard to the budgetary targets they have set for themselves, where they are not obliged to make such payments;
- (b) where they are obliged to make payments in respect of locum cover pursuant to Part 4, the circumstances in which they are likely to make payments in respect of locum cover of less than the maximum amount payable (for example to take account of less than full-time working);
- (c) how they are likely to exercise their discretionary powers to make payments in respect of cover for absent GP performers which is provided by nurses or other health care professionals; and
- (d) how they are likely to exercise their discretionary powers to make payments to a partner or shareholder in a contractor, or an employee of a contractor, who is providing locum cover for an absent GP performer who is also a partner or shareholder in, or an employee of, the contractor.

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

### ***Adjustment of Contractor Registered Populations***

21.18 The starting point for the determination of a contractor's Contractor Registered Population is the number of patients recorded in the Exeter Registration System as being registered with the contractor, initially when its GMS contract takes effect and thereafter at the start of each quarter, when a new number must be established.

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

- (a) if a contractor satisfies a PCT that a patient who registered with it before the start of a quarter was not included in the number of patients recorded in the Exeter Registration System as being registered with it at the start of that quarter, and the PCT received notification of the new registration within 48 hours of the start of that quarter, that patient—
  - (i) is to be treated as part of that contractor's Contractor Registered Population at the start of that quarter, and
  - (ii) is not to be treated as part of any other contractor's Contractor Registered Population at the start of that quarter (and the PCT must notify any other PCT that will need to adjust another contractor's Contractor Registered Population accordingly);

- (b) if, included in the number of patients recorded in the Exeter Registration System as being registered with a contractor at the start of a quarter, there are patients who–
  - (i) transferred to another contractor in the quarter before the previous quarter (or earlier), but
  - (ii) notification of that fact was not received by the PCT until after the second day of the previous quarter,

those patients are not to be treated as part of the contractor's Contractor Registered Population at the start of that quarter; or

- (c) if a patient is not recorded in the Exeter Registration System as being registered with a contractor at the start of a quarter, but that patient–
  - (i) had been removed from a contractor's patient list in error, and
  - (ii) was reinstated in the quarter before the previous quarter (or earlier),

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

21.20 If a contractor wishes its Contractor Registered Population to be adjusted in accordance with paragraph 2.19, it must–

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

and the PCT must seek to resolve the matter as soon as is practicable. If there is a dispute in connection with the adjustment, paragraphs 21.14 and 21.15 apply.

## **22. Superannuation contributions**

### ***PCTs' responsibilities in respect of contractors' employer's and employee's superannuation contributions***

22.1 Under the NHS Pension Scheme Regulations, contractors are responsible for paying the employer's superannuation contributions of practice staff who are members of the NHS Pension Scheme, and collecting and forwarding to the NHS Pensions Agency both employer's and employee's superannuation contributions in respect of their practice staff.

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

22.3 PCTs are also responsible for paying the employer's superannuation contributions of a contractor's members of the NHS Pension Scheme who are–

- (a) GP performers who are not GP Registrars;
- (b) non-practising GP partners and non-GP partners, if the contractor is a partnership; or
- (c) non-practising GP shareholders and non-GP shareholders, if the contractor is a company limited by shares,

in respect of their NHS superannuable profits from all sources – unless superannuated for the purposes of the NHS Pension Scheme elsewhere – whether or not these earnings are derived from payments under this SFE. In this Section, the three categories of people set out in sub-paragraphs (a) to (c) are referred to as “partner/GPs”.

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

- (a) any other arrangements that the contractor has entered into to provide medical services to the NHS, whether or not under its GMS contract, will have included provision for all the payable superannuation contributions in respect of its partner/GPs in the contract price; and
- (b) the payments from the PCT to the contractor in respect of services under the GMS contract, together with the contract price of any other contract to provide medical services to the NHS that the contractor has entered into, also cover the cost of any additional voluntary contributions that the PCT is obliged, as its partner/GPs' employer for superannuation purposes, to make to the NHS Pensions Agency or an Additional Voluntary Contributions Provider on the partner/GPs' behalf.

22.5 Accordingly, the costs of paying the employer's and employee's superannuation contributions of a contractor's partner/GPs under the NHS Pensions Scheme in respect of their NHS superannuable profits from all sources – unless superannuated for the purposes of the NHS Pension Scheme elsewhere – are all to be deducted by the PCT from the money the PCT pays to the contractor pursuant to this SFE.

***Monthly deductions in respect of superannuation contributions***

22.6 The deductions are to be made in two stages. First, PCTs must, as part of the calculation of the net amount (as opposed to the gross amount) of a contractor's Payable GSMPs, deduct an amount that represents a reasonable approximation of a monthly proportion of–

- (a) the PCT's liability for the financial year 2004 to 2005 in respect of the employer's superannuation costs under the NHS Pension Scheme relating to any of the contractor's partner/GPs who are members of the Scheme;
- (b) those partner/GPs' related employee's superannuation contributions; and
- (c) any payable additional voluntary contributions in respect of those partner/GPs.

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

22.7 An amount equal to the monthly amount that the PCT deducts must be remitted to NHS Pensions Agency and any relevant Money Purchase Additional Voluntary Contributions Providers no later than–

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

### ***End-year adjustments***

22.8 Then, after the end of the financial year, the final amount of each partner/GP's superannuable income in respect of the financial year will need to be determined.

22.9 For these purposes, the superannuable income of–

- (a) a salaried GP who is an employee of the contractor, or of a partner/GP who is a shareholder in a contractor that is a company limited by shares, will be–
  - (i) his earnings – less expenses, bonuses or overtime – from his contract of employment with the contractor, and
  - (ii) his income from any Golden Hello Payment, Returners' Scheme Doctor Payment, Flexible Career Scheme Doctor Payment or Seniority Payment paid in respect of him to the contractor pursuant to Part 4; or

- (b) any other partner/GP will be–
  - (i) in the case of a sole practitioner, his NHS profits from all sources, and
  - (ii) in the case of a partner in a partnership, his share of the partnership’s NHS profits, together with his income from any Golden Hello Payment, Returners’ Scheme Payment or Seniority Payment paid in respect of him to the contractor pursuant to Part 4.

22.10 As regards contractors that are partnerships, sole practitioners or companies limited by shares, it is a condition of all the payments payable pursuant to Parts 1 to 3 of this SFE – if any of the contractor’s partner/GPs are members of the NHS Pension Scheme – that the contractor ensures that its partner/GPs (other than those who are neither members of the NHS Pension Scheme nor due Seniority Payments) prepare, sign and forward to the PCT within what, in all the circumstances, is a reasonable time an accurate certificate, in the standard format provided nationally, which provides the following information–

- (a) the contractor’s NHS superannuable profits in respect of the financial year 2004 to 2005 (i.e. for the tax year, which may be different from the contractor’s own accounting year);
- (b) in the case of–
  - (i) a partner in a partnership, his own share of those profits, or
  - (ii) a shareholder in a company limited by shares, his earnings – less expenses, bonuses or overtime – from his contract of employment with the contractor; and
- (c) his NHS profits from all other sources, if these are not superannuated (for the purposes of the NHS Pension Scheme) elsewhere.

22.11 Seniority Payments have to be separately identifiable in the certificate for the purposes of the calculation of Average Adjusted Superannuable Income, which is necessary for the determination of the amount of GP providers’ Seniority Payments. Seniority Payment figures in the certificates forwarded to PCTs will necessarily be provisional (unless they are submitted too late for the information they contain to be included in the Average Adjusted Superannuable Income calculation), but the forwarding of certificates must not be delayed simply because of this. Partner/GPs who are not members of the NHS Pension Scheme but in respect of whom a claim for a Quarterly Seniority Payment is to be made must prepare, sign and forward the certificate to the PCT so that the correct amount of their Seniority Payments for the financial year 2004 to 2005 may be determined.

22.12 Once a contractor’s partner/GPs’ superannuable earnings in respect of the financial year 2004 to 2005 have been agreed, the PCT must–

- (a) pay any outstanding NHS Pension Scheme employer's and employee's superannuation contributions due in respect of those earnings to the NHS Pensions Agency or any relevant Additional Voluntary Contributions Provider (having regard to the payments it has already made on account in respect of those partner/GPs for the financial year 2004 to 2005); and
- (b) if its deductions from the contractor's Payable GSMPs during the financial year 2004 to 2005 relating to the superannuation contributions in respect of those earnings–
  - (i) did not cover the cost of all the employer's and employee's superannuation contributions that are payable by the PCT or the partner/GPs in respect of those earnings–
    - (aa) deduct the amount outstanding from any payment payable to the contractor under its GMS contract pursuant to this SFE (and for all purposes the amount that is payable in respect of that payment is to be reduced accordingly), or
    - (bb) obtain payment (where no such deduction can be made) from the contractor of the amount outstanding, and it is a condition of the payments made pursuant to this SFE that the contractor must pay to the PCT the amount outstanding, or
  - (ii) were in excess of the amount payable by the PCT and the partner/GP to the NHS Pensions Agency or a relevant Money Purchase Additional Voluntary Contributions Provider in respect of those earnings, repay the excess amount to the contractor promptly (unless, in the case of an excess amount in respect of Money Purchase Additional Voluntary Contributions, the contributor elects for that amount to be a further contribution and he is entitled to so elect).

### ***Locums***

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

## **ANNEX A**

## **GLOSSARY**

### **PART 1**

## ACRONYMNS

The following acronyms are used in this document:

CFMP – Correction Factor Monthly Payment  
CPI – Contractor Population Index  
CRP – Contractor Registered Population  
CWP – Contractor Weighted Population  
FCS – Flexible Careers Scheme  
FYOIP – Five-Year-Olds Immunisation Payment  
GMS – General Medical Services  
GSE – Global Sum Equivalent  
GSMP – Global Sum Monthly Payment  
IAS – Improved Access Scheme  
LMC – Local Medical Committee  
MPIG – Minimum Practice Income Guarantee  
NHS – National Health Service  
PCT – Primary Care Trust  
PPA – Prescription Pricing Authority  
QOF – Quality and Outcomes Framework  
QuIPS – Quality Information Preparation Scheme  
RS – Returners’ Scheme  
SHA – Strategic Health Authority  
TYOIP – Two-Year-Olds Immunisation Payment

## PART 2

### DEFINITIONS

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

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

“The 1977 Act” means the National Health Service Act 1977<sup>1</sup>. This Act was significantly amended (for the purposes of this SFE) by the Health and Social Care (Community Health and Standards) Act 2003<sup>2</sup>.

“The 2003 Order” means the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003<sup>3</sup>.

“The 2004 Order” means the General Medical Services Transitional and Consequential Provisions Order 2004.<sup>4</sup>

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<sup>1</sup> 1977 c.49.

<sup>2</sup> 2003 c.43.

<sup>3</sup> S.I.2003/1250.

<sup>4</sup> S.I. 2004/433.

“The 2004 Regulations” means the National Health Service (General Medical Services Contracts) Regulations 2004<sup>1</sup>.

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

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

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

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

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

“Contractor Population Index” is the number produced by dividing a contractor’s most recently established CRP by 5891.

“Contractor Registered Population”, in relation to a contractor, means – subject to any adjustment made in accordance with paragraph 21.19 – the number of patients recorded in the Exeter Registration System as being registered with the contractor, initially when its GMS contract takes effect and thereafter at the start of each quarter, when a new number must be established.

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

“Correction Factor Monthly Payment” is to be construed in accordance with paragraph 3.8.

“Default contract” means a contract entered into under article 13 of the 2004 Order.

“DES Directions” means the Primary Medical Services (Directed Enhanced Services) (England) Directions 2004.

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

- (a) a sole practitioner who is the contractor;

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<sup>1</sup> S.I. 2004/291.

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

“Final Global Sum Equivalent” is to be construed in accordance with paragraph 3.3.

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

“General Practitioner” means–

- (a) on the coming into force of article 10 of the 2003 Order, a medical practitioner whose name is included in the General Practitioner Register; and
- (b) until the coming into force of the said article 10, a medical practitioner who is either–
  - (i) until the coming into force of paragraph 22 of Schedule 8 to the 2003 Order–
    - (aa) suitably experienced within the meaning of section 31(2) of the 1977 Act, section 21 of the National Health Service (Scotland) Act 1978 or Article 8(2) of the Health and Personal Social Services (Northern Ireland) Order 1978, or
    - (bb) has an acquired right to practise as a general medical practitioner by virtue of regulation 5(1)(d) of the Vocational Training for General Medical Practice (European Requirements) Regulations 1994<sup>1</sup>, or
  - (ii) upon the coming into force of paragraph 22 of Schedule 8 to the 2003 Order, an eligible general practitioner pursuant to that paragraph.

“Global Sum Equivalent” is to be construed in accordance with paragraph 3.1.

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<sup>1</sup> S.I. 1994/3130.

“GMS contract” means a general medical services contract under section 28Q of the 1977 Act.

“GP performer” means a general practitioner—

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

“GP provider” means a GP who is—

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

“Historic Opt-Outs Adjustment” is to be construed in accordance with paragraphs 3.5 and 3.6.

“Improved Access Scheme plan” is to be construed in accordance with paragraph 6.3.

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

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

“London Adjustment” is to be construed in accordance with paragraph 2.3.

“Medical performers list” is to be construed in accordance with regulation 3(1) of the Performers List Regulations.

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

“Money Purchase Additional Voluntary Contributions Provider” means an insurance company providing what, for the purposes of the National Health Service Pension Scheme (Additional Voluntary Contributions) Regulations 2000<sup>1</sup>, is a free-standing additional voluntary contributions scheme.

“Money Purchase Additional Voluntary Contributions” means contributions to a Money Purchase Additional Voluntary Contributions Provider in respect of what, for

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<sup>1</sup> S.I. 2000/619.

the purposes of the National Health Service Pension Scheme (Additional Voluntary Contributions) Regulations 2000, is a free-standing additional voluntary contributions scheme.

“NHS Pension Scheme Regulations” means the National Health Service Pension Scheme Regulations 1995<sup>1</sup>, as amended.

“Non-GP partner” means a partner in a contractor that is a partnership who is not a GP.

“Non-GP shareholder” means a shareholder in a contractor that is a company limited by shares who is not a GP.

“Non-practising GP partner” partner means a partner in a contractor that is a partnership who is a GP but who does not perform medical services under the contractor’s GMS contract.

“Non-practising GP shareholder” means a shareholder in a contractor that is a company limited by shares who is a GP but who does not perform medical services under the contractor’s GMS contract.

“Partner/GPs” means–

- (a) GP performers who are not GP Registrars,
- (b) non-practising GP partners and non-GP partners in a contractor that is a partnership, if they are members of the NHS Pension Scheme; or
- (c) non-practising GP shareholders and non-GP shareholders in a contractor that is a company limited by shares, if they are members of the NHS Pensions Scheme.

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

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

“Performers List Regulations” means the National Health Service (Performers List) Regulations 2004<sup>1</sup>.

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<sup>1</sup> S.I. 1995/300; as amended.

“PMS contract” means section 28C arrangements.

“PMS contractor” means a section 28C provider.

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

“Quarter” means a quarter of the financial year.

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

“Red Book” means the Statement of Fees and Allowances under regulation 34 of the National Health Service (General Medical Services) Regulations 1992, as it had effect on 31st March 2004. However, for the purposes of paragraph 13.13(a), it means the Statement of Fees and Allowances under regulation 34 of the National Health Service (General Medical Services) Regulations 1992, as it had effect on 31st March 2003.

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

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

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

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

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<sup>1</sup> S.I. 2004/585.

## ANNEX B

### THE GLOBAL SUM ALLOCATION FORMULA

#### Introduction

B.1 The global sum will be allocated using the new Global Sum Allocation Formula. This formula aims to ensure that resources reflect more accurately the contractor's workload and the unavoidable costs of delivering high quality care to the local population.

B.2 The new formula consists of the following components:

- an adjustment for the age and sex structure of the population;
- an adjustment for the additional needs of the population, relating to morbidity and mortality;
- an adjustment for list turnover;
- a nursing and residential homes index;
- adjustments for the unavoidable costs of delivering services to the population, including a Market Forces Factor and rurality index.

#### Age and sex adjustment

B.3 The analysis supporting the new formula estimates the relative workload, weighted by staff input cost, of providing general medical services to males and females of a number of age groups. The table below, based on analysis of the General Practice Research Database, shows these indices (expressed relative to a male patient aged 5-14), including an adjustment for the higher workload of treating patients through home visits.

Table C1: Age-sex workload indices (males aged 5-14 = 1).

	0-4	5-14	15-44	45-64	65-74	75-84	85+
Male	3.97	1	1.02	2.15	4.19	5.81	6.27
Female	3.64	1.04	2.19	3.36	4.9	6.56	6.72

B.4 Therefore, each male patient on a contractor's list aged over 85 will attract 6.27 times the resources for a male patient aged 5-14.

#### Nursing and Residential Homes

B.5 Patients in nursing and residential homes generate more workload than patients with otherwise similar characteristics who are not in homes. A factor of 1.43 is applied in respect of each patient in a nursing or residential home.

## **Needs adjustment**

B.6 As well as the impact on contractors' workload generated by differing age and sex groups, the effect of indicators of mortality and morbidity on consultation frequency has been estimated, using the Health Survey for England.

B.7 Of all the variables tested by the supporting analysis, Standardised Limited Long-Standing Illness (SLLI) and the Standardised Mortality Ratio for those aged under 65 (SMR<65) were found to be best at explaining variations in workload.

B.8 The Global Sum Allocation Formula relates these variables to workload by the following formula:

$$\text{Practice list} * (48.1198 + (0.26115 * \text{SLLI}) + (0.23676 * \text{SMR}<65)).$$

## **List turnover adjustment**

B.9 Areas with high list turnover often have higher workload, as patients in their first year of registration in a practice tend to have more consultations than other patients.

B.10 Analysis of the workload implications revealed 40-50% more workload, as measured by aggregate consultation times, within the first year of registration. An average uplift factor, of 1.46, will be applied through the formula in respect of all new registrants in their first year of registration.

## **Unavoidable costs adjustment**

B.11 Contractors are also likely to face differing costs of delivering primary care, particularly caused by geographic location. The global sum allocation formula reflects these costs through an explicit adjustment for 'market forces' and rurality. (There is also an 'off-formula' adjustment for contractors whose PCT is within the area of a London SHA.)

### *Staff Market Forces*

B.12 The staff MFF has been informed by analysis of the New Earnings Survey, and reflects the geographical variation in contractors' staff costs. The estimation methodology is the same as that used for general NHS allocations.

B.13 This element of the formula has been given a weighting of 48%, as this is the average proportion of the global sum accounted for by staff expenses.

### *Rurality*

B.14 The cost of delivering services is likely to be affected by the rurality of the area the practice serves. Two measures designed to reflect rurality were used: population density (as measured by persons per hectare in the wards from which a contractor draws its patients) and population dispersion (as measured by the average distance from patients to practice). If a practice has more than one surgery, the

average distance is assessed from the practice's principal surgery, which is defined as the surgery which the greatest number of the practice's patients could reasonably be expected to attend.

B.15 Using analysis of the Inland Revenue information on GP expenses, rurality is linked to cost through the following adjustments to the formula:

$$\text{Practice list} * ((0.05 * \log \text{ average distance}) - (0.06 * \log \text{ population density}))$$

B.16 This adjustment is applied only to the expenses element of GMS expenditure, and therefore given an overall weighting of 58%.

### **Normalising the adjustments**

B.17 At each stage of the calculation, the weighted practice populations are normalised (scaled back) to the PCT weighted population, which itself is normalised to the national registered population (see B.18 below). This is done so that the impact of each of the adjustments is equal, and ensures that one adjustment does not dominate the others. The formula for normalising practice weighted populations is as follows:

$$\text{Normalised weighted practice population} = \text{Weighted practice population} * \frac{\text{PCT weighted population}^1}{\text{Sum of practice weighted populations in the PCT}}$$

B.18 The PCT normalised weighted population used above is the PCT's registered population multiplied by its normalising index, which is calculated for a financial year and derived by the Department of Health from the data underpinning allocations. Scaling back to this population ensures that the needs and costs of the PCT's population, relative to other PCTs in the country, are reflected in its practices' global sums.

B.19 The normalised weighted population for each adjustment is then divided by the practice's unweighted registered list, to generate a practice index for each adjustment.

### **Combining the adjustments**

B.20 Each of the six indices are then applied simultaneously to the practice's unweighted registered list, as follows:

$$\text{Practice list} * \text{age/sex index} * \text{nursing and residential homes index} * \text{list turnover index} * \text{additional need index} * \text{MFF index} * \text{rurality index}$$

B.21 As in B.17 above, this practice weighted population is then normalised to the PCT's weighted population, which has itself been normalised to the national registered population. The result of this calculation is the contractor's Contractor Weighted Population for the Quarter.

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<sup>1</sup> Normalised to the national registered population.

B.22 PCTs will have the use of software that will enable them to calculate the contractor weighting for each contractor, provided the necessary raw data have been collated.

## ANNEX C

### TEMPORARY PATIENTS ADJUSTMENT

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

C.2 All contractors are to receive a payment for unregistered patients as an element in their global sum allocation. The amount each contractor receives in respect of such patients is generally to be based on the average amount that, historically, the contractor's practice has claimed in respect of treating such patients each year under the Red Book prior to 1st April 2004.

C.3 In a case where that practice has been providing general medical services for five years or more, prior to 1st April 2003, the annual amount which is to be the basis of its Temporary Patients Adjustment is to be calculated as the average annual amount claimed in respect of treating unregistered patients over the most recent five years (i.e. the aggregate of the five yearly totals divided by five). For the purposes of the calculation, the amounts claimed are to be uprated by the following amounts—

- claims in respect of the financial year 1998/1999: 24.58%
- claims in respect of the financial year 1999/2000: 15.02%
- claims in respect of the financial year 2000/1: 10.75%
- claims in respect of the financial year 2001/2: 9.13%
- claims in respect of the financial year 2002/3: 4.36%

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

C.5 If a contractor does not have five years' worth of data, the PCT is instead to determine for the contractor, as the basis for its Temporary Patients Adjustment, a reasonable annual amount (having taken into account whatever historic data the contractor does have in respect of temporary residents fees, emergency treatment fees and immediately necessary treatment fees) which is an appropriate rate for the area where the practice is located.

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

C.7 Once a Temporary Patients Adjustment has been determined, it remains unchanged for the financial year 2004 to 2005.

## ANNEX D

### MPIG GUIDANCE

#### *Calculation of GSE*

D.1 The calculation of GSE is based on expenditure for the last three quarters of 2002-03 plus the first quarter of 2003-04. This will be subject to an uplift to 2004-05 prices by national uplifts in accordance with paragraph 3.3.

D.2 The GSE will also be adjusted to take account of changes in list size. The Initial GSE for the baseline period (July 2002 – June 2003) will be divided by the average CRP for the period, and then multiplied by the CRP on 1st April 2004. This is to take account of growing or shrinking practices.

D.3 The GSE covers the following expenditure<sup>1</sup>–

- (i) Basic practice allowance
- (ii) Night consultation fees
- (iii) Night annual payments
- (iv) Capitation fees
- (v) Health promotion annual payments (excluding chronic disease management)
- (vi) Contraceptive services fees (excluding intrauterine device fees)
- (vii) Maternity medical services fees (excluding intra partum care)
- (viii) Deprivation payments
- (ix) New registration fees
- (x) Minor surgery fees (part)
- (xi) Child health surveillance fees
- (xii) Vaccinations and immunisations item-of-service fees (excluding influenza, and childhood immunisation and pre-school booster target payments)
- (xiii) Arrest of dental haemorrhage fees
- (xiv) Rural practice payments
- (xv) Postgraduate education allowance
- (xvi) Telephone advice fees
- (xvii) Cervical cytology target payments (part)
- (xviii) Anaesthetic administration fees
- (xix) Inducement payments
- (xx) Practice staff reimbursements (including employer's NI)
- (xxi) GP superannuation payments (i.e. paid by employer PCTs in the baseline period) – this amount is to be doubled.

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<sup>1</sup> PCTs should note that, contrary to what was originally intended, temporary residents fees, emergency treatment fees and immediately necessary treatment fees do not feature in the list. They should also note the special treatment of maternity medical services fees, minor surgery fees and cervical cytology target payments in the text below and in the appendix.

D.4 **Appendix A** maps the constituents of the GSE to the relevant lines in the PFR1 financial return and the FIMS(FHS)4 return.

D.5 GSE payments for these periods should be available from the Exeter Payments System.

D.6 Cash payments for the first quarter of 2003-04 should be at 2002-03 prices. This is because the 2003-04 pay deal, including the general uplift to fees and allowances, did not become effective until October and the backdated arrears are being recorded as a separate lump sum.

D.7 PCTs should note the following about certain constituents of the GSE:

- (a) *maternity medical services fees (excluding intra partum care)*  
the GSE excludes expenditure on intra partum care. This expenditure is not separately identified in the accounts. Identification of these payments is to be agreed by the PCT and the contractor, as the level of expenditure will differ between practices;
- (b) *minor surgery fees (part)*  
this should be based on one-third of the contractor's minor surgery fees income on the basis that one-third of expenditure on minor surgery is included in the GSE;
- (c) *cervical cytology target payments (part)*  
this should be based on one-half of the contractor's cervical cytology lower and higher target payments on the basis that one-half of expenditure on cervical cytology is included in the GSE; and
- (d) *GP superannuation payments*  
this amount is to be doubled to take account of the additional 7% employer's superannuation contributions in respect of GPs as a result of the Treasury transfer.

#### ***Treatment of unusual practices***

D.8 The configuration of practices is not static. This means that there will be cases where expenditure data will not be readily available for the practices as currently configured. In such cases PCTs will need to map GSE payments according to the guidance below.

#### ***GP vacancies during the baseline period***

D.9 Calculation of the GSE will take account of GP vacancies during the baseline period. There are two separate criteria for assessing whether a vacancy adjustment should be made. These are–

- (a) where the practice has a PCT-approved vacancy overlapping the baseline period at any time; or

- (b) where the practice loses one or more principals during the baseline period at any time, and where approval for replacement has been agreed.

D.10 In such cases the adjustment will be made on a per day, per vacancy basis for each day during the baseline period. PCTs should count vacancies from the day they occur and not from the day they were approved.

D.11 Where the vacancy is full-time the full-time rate will apply. As per the current Standard Fees and Allowances (SFA) rules, where it is three-quarter-time, 83.5% of the full rate should apply, where it is half-time, 62.5% should apply, and where it is one-quarter-time, 41.5% should apply. The absence of a job-sharer should be calculated *pro rata* to that absent job-sharer's availability.

D.12 The full-time vacancy cost factor is £19,931.

### ***Staff vacancies***

D.13 PCTs may add in an adjustment in respect of staff vacancies, or new staff posts, where appropriate.

### ***Practices that merged during the period covered by the data collection (between 1 July 2002 and 30 June 2003)***

D.14 Some practices may have merged during the baseline period. In these circumstances, the GSE should be the sum of the constituent practices' GSE income in the part of the year before they merged, plus the new practice's GSE income for the rest of the year. For example—

Practices A and B merge to form Practice C on 1 April 2003

GSE for Practice A (up to end March)	=	£200k
GSE for Practice B (up to end March)	=	£150k
GSE for Practice C (April to end June)	=	£120k
Full year GSE for Practice C	=	£470k

### ***Practices that split during the period covered by the data collection (between 1 July 2002 and 30 June 2003)***

D.15 Some practices in existence during the first quarter of 2003-04 will have previously been part of another practice. For the part of the year where data are available for the new practices, these data should be used.

D.16 For the part of the year before the practice split, the GSE for the new practices will have to be based on the GSE of the old practice. GSE income for the new practices will be calculated *pro rata* to the practice list size at the time of the split. For example—

Practice X splits into Practice Y and Practice Z on 31 March 2003

Practice X GSE (1 July 2002 to 31 March 2003)	=	£400k
Practice X list size	=	2,500
Practice Y list size	=	1,000
Practice Y GSE (1 April to 30 June 2003)	=	£50k
Practice Y GSE (1 July 2002 to 31 March 2002)	=	£160k
Practice Y full year GSE	=	£210k
Practice Z list size	=	1,500
Practice Z GSE (1 April to 30 June 2003)	=	£65k
Practice Z GSE (1 July 2002 to 31 March 2002)	=	£240k
Practice Z full year GSE	=	£305k

***Practices that formed during the period covered by the data collection (between 1 July 2002 and 30 June 2003)***

D.17 If a practice formed during the baseline period, the GSE should be calculated on any part-year data that are available and then grossed up to the full-year figure.

***Practices that merge after the period covered by the data collection (quarter 1 2003-04) but before 1 April 2004***

D.18 Some practices that existed up to the first quarter of 2003-04 will have subsequently merged with others during 2003-04. In these circumstances, the GSE for the new practice should be the sum of the GSEs for the constituent practices before the merger.

***Practices that split after the period covered by the data collection (quarter 1 2003-04) but before 1 April 2004***

D.19 Some practices that existed up to first quarter 2003-04 will have subsequently split and formed different practices during 2003-04. In these circumstances, the GSE for the new practices will be based on the old practice's GSE shared pro-rata on a list size basis.

***New practices in 2003-04***

D.20 Practices forming in 2003-04 will be eligible for an MPIG. It will be based on the funding for the GSE items for the months in which they have been in existence, increased *pro rata* to a full year.

**Appendix A to Annex D: Constituents of the global sum equivalent mapped to financial returns**

<b>GSE constituent</b>	<b>Description in financial returns</b>	<b>PFR1 code</b>	<b>FIMS(FHS)4 code</b>
Basic practice allowance	Basic practice allowance	141	1141
Night consultation fees	Night consultation fee	167	1167
Night annual payment	OOH Allowance	168	1168
Capitation fees	Capitation fees under 65	150	1150
	Capitation fees 65-74	151	1151
	Capitation fees over 75	152	1152
Health promotion annual payment (excluding chronic disease management)	Sessional fees for health promotion	180	11810
Contraceptive services fees (excluding intrauterine device fees)	Contraceptive service – ordinary	175	1175
Maternity medical services fees (excluding intra partum care) <sup>1</sup>	Maternity medical services	185	1185
Deprivation payments	Ward based deprivation payment – higher	145	1145
	Ward based deprivation payment – medium	146	1146
	Ward based deprivation payment – lower	147	1147
	Enumeration district based deprivation payment - band 1	148a	11491
	Enumeration district based deprivation payment - band 2	148b	11492
	Enumeration district based deprivation payment - band 3	148c	11493
	Enumeration district based deprivation payment - band 4	148d	11494
New registration fees	Registration fees	160	1160
Minor surgery fees (part) <sup>2</sup>	Minor surgery sessional payments	230	1230
Child health surveillance fees	Child health surveillance fees	155	1155
Vaccinations and immunisations item-of-service fees (excluding influenza, and childhood immunisations and pre-school booster target payments)	MMR2	169	1171
	Vaccination/immunisation	170	1170
	Immunisation against group C meningococcal disease - 2,3,4 month routine vaccines	172a	1172
	Immunisation against group C meningococcal disease - 5 months to under 11 months catch up	172b	11721
	Immunisation against group C meningococcal disease - 12 months – under 5 years	172c	11722
	Immunisation against group C meningococcal disease - university students	172d	11723
	Immunisation against group C meningococcal disease - persons aged 15-17 not in full-time education	172e	11724
Arrest of dental haemorrhage	Arrest of dental haemorrhage	205	1205

<b>GSE constituent</b>	<b>Description in financial returns</b>	<b>PFR1 code</b>	<b>FIMS(FHS)4 code</b>
fees			
Rural practice payments	Rural practice payments - total cost of units	235	1235
	Rural practice allowance - non units	236	1236
Post graduate education allowance	PGEA - full	215	1215
	PGEA - level 4	216	1216
	PGEA - level 3	217	1217
	PGEA - level 2	218	1218
	PGEA - level 1	219	1219
Telephone advice fees	Telephone advice for temporary residents and emergency treatment compensation payments	197	1197
Cervical cytology target payments (part) <sup>3</sup>	Cervical cytology target payments - higher	111	1111
	Cervical cytology target payments - lower	112	1112
Anaesthetic administration fees	Service as an anaesthetist	200	1200
Inducement payments	Inducement payments	120	1120
Practice staff reimbursements	Practice staff	603	1605
	Salaried doctors under para 52 of SFA	605	1607
	Payments made in respect of replacement doctors (SFA 52.41 and 42 salaried doctors)	605A	16071
GP superannuation	Superannuation contributions (employers share) – this amount is to be doubled	250	1290+1291

<sup>1</sup> The GSE excludes expenditure on *intra partum* care. This expenditure is not separately identified in the accounts. Identification of these payments is to be agreed by the PCT and the contractor, as the level of expenditure will differ between practices.

<sup>2</sup> The GSE should include one-third of the contractor's minor surgery payments on the basis that only one-third of expenditure on minor surgery is covered by the GSE.

<sup>3</sup> The GSE should include one-half of the contractor's cervical cytology lower and higher target payments on the basis that only one-half of expenditure on cervical cytology is covered by GSE.

## ANNEX E

### **QUALITY AND OUTCOMES FRAMEWORK**

#### **Guidance**

##### **SECTION 1: PRINCIPLES**

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

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

## **SECTION 2: CLINICAL INDICATORS**

### **1. General format**

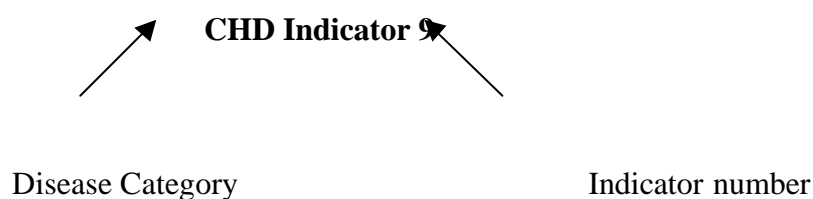
The clinical indicators are organised by disease category. The disease categories have been selected for the following reasons:

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

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

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

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



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

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

For each indicator two descriptions are given. This differs from the first version of the Guidance as the preferred coding section has been removed.

## **1.1 Rationale**

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

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

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

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

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

## **1.2 Reporting and Verification**

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

It is hoped that all reporting will be possible through the use of GP clinical systems and that practices will be able to run a report annually which can be submitted to the PCO. Separate guidance has been produced on the electronic queries which can be used to report on the Quality and Outcomes Framework. This can be found at the following location: <http://www.bma.org.uk/ap.nsf/Content/newreadcodes>

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

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

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

## **2. Exception reporting**

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

The following criteria have been agreed for exception reporting:

- A) patients who have been recorded as refusing to attend review who have been invited on at least three occasions during the preceding twelve months
- B) patients for whom it is not appropriate to review the chronic disease parameters due to particular circumstances eg terminal illness, extreme frailty
- C) patients newly diagnosed within the practice or who have recently registered with the practice, who should have measurements made within three months and delivery of clinical standards within nine months eg blood pressure or cholesterol measurements within target levels
- D) patients who are on maximum tolerated doses of medication whose levels remain sub-optimal
- E) patients for whom prescribing a medication is not clinically appropriate eg those who have an allergy, another contraindication or have experienced an adverse reaction
- F) where a patient has not tolerated medication

- G) where a patient does not agree to investigation or treatment (informed dissent), and this has been recorded in their medical records
- H) where the patient has a supervening condition which makes treatment of their condition inappropriate eg cholesterol reduction where the patient has liver disease
- I) where an investigative service or secondary care service is unavailable.

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

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

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

Practices should report the number of exceptions for each indicator set and individual indicator. An IT solution is currently being devised for exception-reporting but at this stage, practices may need to devise a paper based or separate spreadsheet recording system for exception-reporting. Whether or not computer-based systems are used, practices will not be expected to report why individual patients were exception-reported. Practices may be called on to justify why they have excepted patients from the quality framework and this should be identifiable in the clinical record.

### **3. Disease registers**

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

and how prevalence will be applied can be found in part 2 of the Statement of Financial Entitlements for 2004/05.

## Summary of all Clinical Indicators

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

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

<i>Indicator</i>	<i>Points</i>	<i>Payment Stages</i>
a contraindication or side-effects are recorded)		
CHD 11. The percentage of patients with a history of myocardial infarction (diagnosed after 1 April 2003) who are currently treated with an ACE inhibitor or angiotensin II antagonist	7	25-70%
CHD 12. The percentage of patients with coronary heart disease who have a record of influenza immunisation in the preceding 1 September to 31 March	7	25-85%
<b>Sub Set – Left Ventricular Dysfunction</b>		
<b>Records</b>		
LVD 1. The practice can produce a register of patients with CHD and left ventricular dysfunction	4	
<b><u>Diagnosis and initial management</u></b>		
LVD 2. The percentage of patients with a diagnosis of CHD and left ventricular dysfunction (diagnosed after 1 April 2003) which has been confirmed by an echocardiogram	6	25-90%
<b>Ongoing Management</b>		
LVD 3. The percentage of patients with a diagnosis of CHD and left ventricular dysfunction who are currently treated with ACE inhibitors (or A2 antagonists)	10	25-70%

### **Stroke and Transient Ischaemic Attacks**

<i>Indicator</i>	<i>Points</i>	<i>Payment Stages</i>
<b>Records</b>		
STROKE 1. The practice can produce a register of patients with Stroke or TIA	4	
STROKE 2. The percentage of new patients with presumptive stroke (presenting after 1 April 2003) who have been referred for confirmation of the diagnosis by CT or MRI scan	2	25-80%
<b>Ongoing Management</b>		
STROKE 3. The percentage of patients with TIA or stroke who have a record of smoking status in the last 15 months, except those who have never smoked where smoking status should be recorded at least once since diagnosis	3	25-90%

<i>Indicator</i>	<i>Points</i>	<i>Payment Stages</i>
STROKE 4. The percentage of patients with a history of TIA or stroke who smoke and whose notes contain a record that smoking cessation advice or referral to a specialist service, if available, has been offered in the last 15 months	2	25-70%
STROKE 5. The percentage of patients with TIA or stroke who have a record of blood pressure in the notes in the preceding 15 months	2	25-90%
STROKE 6. The percentage of patients with a history of TIA or stroke in whom the last blood pressure reading (measured in last 15 months) is 150/90 or less	5	25-70%
STROKE 7. The percentage of patients with TIA or stroke who have a record of total cholesterol in the last 15 months	2	25-90%
STROKE 8. The percentage of patients with TIA or stroke whose last measured total cholesterol (measured in last 15 months) is 5 mmol/l or less	5	25-60%
STROKE 9. The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken (unless a contraindication or side-effects are recorded)	4	25-90%
STROKE 10. The percentage of patients with TIA or stroke who have had influenza immunisation in the preceding 1 September to 31 March	2	25-85%

## Hypertension

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

## Diabetes Mellitus (Diabetes)

<i>Indicator</i>	<i>Points</i>	<i>Payment Stages</i>
<b>Records</b>		
DM 1. The practice can produce a register of all patients with diabetes mellitus	6	
<b>Ongoing Management</b>		
DM 2. The percentage of patients with diabetes whose notes record BMI in the previous 15 months	3	25-90%
DM 3. The percentage of patients with diabetes in whom there is a record of smoking status in the previous 15 months, except those who have never smoked where smoking status should be recorded once	3	25-90%
DM 4. The percentage of patients with diabetes who smoke and whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered in the last 15 months	5	25-90%
DM 5. The percentage of diabetic patients who have a record of HbA1c or equivalent in the previous 15 months	3	25-90%
DM 6. The percentage of patients with diabetes in whom the last HbA1C is 7.4 or less (or equivalent test/reference range depending on local laboratory) in last 15 months	16	25-50%

DM 7. The percentage of patients with diabetes in whom the last HbA1C is 10 or less (or equivalent test/reference range depending on local laboratory) in last 15 months	11	25-85%
DM 8. The percentage of patients with diabetes who have a record of retinal screening in the previous 15 months	5	25-90%
DM 9. The percentage of patients with diabetes with a record of the presence or absence of peripheral pulses in the previous 15 months	3	25-90%
DM 10. The percentage of patients with diabetes with a record of neuropathy testing in the previous 15 months	3	25-90%
DM 11. The percentage of patients with diabetes who have a record of the blood pressure in the past 15 months	3	25-90%
DM 12. The percentage of patients with diabetes in whom the last blood pressure is 145/85 or less	17	25-55%
DM 13. The percentage of patients with diabetes who have a record of micro-albuminuria testing in the previous 15 months (exception reporting for patients with proteinuria)	3	25-90%
DM 14. The percentage of patients with diabetes who have a record of serum creatinine testing in the previous 15 months	3	25-90%
DM 15. The percentage of patients with diabetes with a diagnosis of proteinuria or micro-albuminuria who are treated with ACE inhibitors (or A2 antagonists)	3	25-70%
DM 16. The percentage of patients with diabetes who have a record of total cholesterol in the previous 15 months	3	25-90%
DM 17. The percentage of patients with diabetes whose last measured total cholesterol within the previous 15 months is 5mmol/l or less	6	25-60%
DM 18. The percentage of patients with diabetes who have had influenza immunisation in the preceding 1 September to 31 March	3	25-85%

### **Chronic Obstructive Pulmonary Disease (COPD)**

<i>Indicator</i>	<i>Points</i>	<i>Payment Stages</i>
<b>Records</b>		
COPD 1. The practice can produce a register of patients with COPD	5	
<b>Initial diagnosis</b>		
COPD 2. The percentage of patients in whom diagnosis has been confirmed by spirometry including reversibility testing for newly diagnosed patients with effect from 1 April 2003	5	25-90%
COPD 3. The percentage of all patients with COPD in whom diagnosis has been confirmed by spirometry including reversibility testing	5	25-90%
<b>Ongoing management</b>		
COPD 4. The percentage of patients with COPD in whom	6	25-90%

<i>Indicator</i>	<i>Points</i>	<i>Payment Stages</i>
there is a record of smoking status in the previous 15 months		
COPD 5. The percentage of patients with COPD who smoke, whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered in the past 15 months	6	25-90%
COPD 6. The percentage of patients with COPD with a record of FeV1 in the previous 27 months	6	25-70%
COPD 7. The percentage of patients with COPD receiving inhaled treatment in whom there is a record that inhaler technique has been checked in the preceding 27 months	6	25-90%
COPD 8. The percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March	6	25-85%

### **Epilepsy**

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

### **Hypothyroidism**

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

previous 15 months		
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## **Cancer**

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

## **Mental Health (MH)**

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

## Asthma

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

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

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

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

<i>Indicator</i>	<i>Points</i>	<i>Payment Stages</i>
myocardial infarction (diagnosed after 1 April 2003) who are currently treated with an ACE inhibitor or Angiotensin II antagonist		
CHD 12. The percentage of patients with coronary heart disease who have a record of influenza immunisation in the preceding 1 September to 31 March	7	25-85%

### **CHD - Rationale for Inclusion of Indicator Set**

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

#### **CHD Indicator 1**

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

#### **CHD 1.1 Rationale**

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

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

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

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

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

#### **CHD Indicator 2**

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

## CHD 2.1 Rationale

Diagnosis of coronary heart disease

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

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

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

*Reference Grade B Recommendation SIGN Guideline 51*

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

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

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

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

Patients should not be referred for an ETT if:

- they are on maximal medical treatment and still have angina symptoms
- the diagnosis of CHD is unlikely (these patients should be referred to a cardiologist)
- they are physically incapable of performing the test
- they have clinical features suggestive of aortic stenosis or cardiomyopathy
- the results of stress testing would not affect management.

*Reference Grade B Recommendation SIGN Guideline 51*

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

### Specialist Referral

An alternative to referral for exercise-testing is referral to a specialist for evaluation. Referral would normally be to a cardiologist, general physician or GP with a special interest. For the purposes of the Quality and Outcomes Framework an appropriate

referral being undertaken between three months before and twelve months after a diagnosis of angina being made would be considered as having met the requirements of this indicator.

## **CHD 2.2 Reporting and Verification**

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

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

Inspection of the output from a computer search that has been used to provide information on this indicator.

Inspection of a sample of records of patients with CHD diagnosed since 1 April 2003 to look at the proportion with recorded exercise tolerance testing or referral

Inspection of a sample of records of patients for whom a record of exercise tolerance testing or referral is claimed, to see if there is evidence of this in the medical records.

### **CHD Indicator 3**

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

## **CHD 3.1 Rationale**

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

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

*Reference SIGN Guideline 41*

*European Task Force European Society of Cardiology*

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

Further Information: <http://www.escardio.org/scinfo/Guidelines/98prevention.pdf>

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

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

### **CHD 3.2 Reporting and Verification**

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

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

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

$$\frac{[no\ of\ never\ smoked] + [no\ recorded\ as\ ex- or\ current\ smokers\ in\ past\ 15\ months]}{[number\ with\ CHD]}$$

### **CHD Indicator 4**

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

#### CHD 4.1 Rationale

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

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

*Reference Grade B recommendation SIGN Guidelines 41/51*

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

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

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

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

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

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

#### **CHD 4.2 Reporting and Verification**

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

<b>CHD Indicator 5</b>
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<b>The percentage of patients with coronary heart disease whose notes have a record of blood pressure in the previous 15 months</b>
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#### **CHD 5.1 Rationale**

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

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

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

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

## **CHD Indicator 6**

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

### **CHD 6.1 Rationale**

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

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

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

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

## **CHD Indicator 7**

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

### **CHD 7.1 Rationale**

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

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

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

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

## **CHD 7.2 Reporting and Verification**

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

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

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

### **CHD Indicator 8**

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

## **CHD 8.1 Rationale**

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

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

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

## **CHD 8.2 Reporting and Verification**

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

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

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

#### **CHD Indicator 9**

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

#### **CHD 9.1 Rationale**

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

*Grade A Recommendation SIGN Guidelines 41/51*

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

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

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

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

#### **CHD Indicator 10**

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

#### **CHD 10.1 Rationale**

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

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

*Grade A Recommendation SIGN Guidelines 41/51*

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

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

## **CHD 10.2 Reporting and Verification**

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

### **CHD Indicator 11**

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

## **CHD 11.1 Rationale**

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

*Grade A Recommendation SIGN Guideline 41*

*Grade A Recommendation NICE Guideline A*

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

Further information: <http://www.escardio.org/scinfo/Guidelines/98prevention.pdf>

## **CHD 11.2 Reporting and Verification**

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

**CHD Indicator 12**

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

**CHD 12.1 Rationale**

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

**CHD 12.2 Reporting and Verification**

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

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

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

## **LVD - Rationale for Inclusion of Indicator Set**

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

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

### **LVD Indicator 1**

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

#### **LVD 1.1 Rationale**

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

#### **LVD 1.2 Reporting and Verification**

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

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

### **LVD Indicator 2**

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

#### **LVD 2.1 Rationale**

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

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

*Grade C recommendation SIGN 35*

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

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

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

## **LVD 2.2 Reporting and Verification**

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

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

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

### **LVD Indicator 3**

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

### **LVD 3.1 Rationale**

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

*Grade A Recommendation SIGN 35*

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

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

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

*Grade A Recommendation SIGN 35*

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

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

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

*Grade A Recommendation SIGN 35*

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

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

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

#### **Stroke and Transient Ischaemic Attacks (TIA)**

<i>Indicator</i>	<i>Points</i>	<i>Payment Stages</i>

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

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

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

#### **Stroke Indicator 1**

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

### **Stroke 1.1 Rationale**

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

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

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

### **Stroke 1.2 Reporting and Verification**

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

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

## **Stroke Indicator 2**

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

### **Stroke 2.1 Rationale**

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

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

- Clinical scoring systems have been found to be unreliable in distinguishing ischaemic and haemorrhagic stroke.

*Grade C Recommendation SIGN 13*

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

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

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

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

## **Stroke 2.2 Reporting and Verification**

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

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

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

<b>Stroke Indicator 3</b>
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**The percentage of patients with TIA or stroke who have a record of smoking status in the last 15 months, except those who have never smoked where smoking status should be recorded at least once since diagnosis**

### Stroke 3.1 Rationale

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

*Grade C Recommendation SIGN 13*

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

### Stroke 3.2 Reporting and Verification

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

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

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

$$\frac{[no\ of\ never\ smoked] + [no\ recorded\ as\ ex- or\ current\ smokers\ in\ past\ 15\ months]}{[number\ with\ stroke/TIA]}$$

### Stroke Indicator 4

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

### Stroke 4.1 Rationale

Smoking cessation evidence has mostly been investigated in the domain of ischaemic heart disease (IHD). Many strategies have been used to help people to stop smoking. A meta-analysis of controlled trials in patients post myocardial infarction showed that a combination of individual and group smoking cessation advice, and assistance

reinforced on multiple occasions - initially during cardiac rehabilitation and reinforced by primary care teams - gave the highest success rates.

*Reference Grade B recommendation SIGN Guidelines 41/51*

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

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

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

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

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

## **Stroke 4.2 Reporting and Verification**

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

### **Stroke Indicator 5**

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

## **Stroke 5.1 Rationale**

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

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

*Grade A Recommendation RCP Stroke Guideline 2002*

Further Information:

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

## **Stroke 5.2 Reporting and Verification**

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

### **Stroke Indicator 6**

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

## **Stroke 6.1 Rationale**

See STROKE 5.1.

## **Stroke 6.2 Reporting and Verification**

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

### **Stroke Indicator 7**

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

## **Stroke 7.1 Rationale**

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

GJ Hankey reviewed the evidence in terms of establishing the role of cholesterol-modifying therapy in stroke prevention. This paper states “Population-based observational cohort studies show a variable weak positive relationship between increasing plasma total cholesterol concentrations and an increasing risk of ischaemic stroke, which is partly offset by a weaker negative association between decreasing total cholesterol concentrations and an increasing risk of haemorrhagic stroke. However, randomised controlled trials show unequivocally that lowering plasma total cholesterol by approximately 1.2 mmol/l (and LDL-cholesterol by 1.0 mmol/l) is associated with a reduced relative risk of stroke and other serious vascular events by at least a quarter, and probably a third, without any increase in haemorrhagic stroke, in a wide range of men and women (including individuals with previous stroke). The proportional reduction in stroke risk is consistent, irrespective of the patient's age, baseline plasma cholesterol concentration, and absolute risk of stroke (although

perhaps less in very low-risk individuals), but is increased with greater degrees of cholesterol lowering (15% or more), and thus with statin medications, which are more potent than non-statin interventions in lowering cholesterol levels. The absolute reduction in stroke risk achieved by statins is greatest among individuals at highest risk of stroke. Preliminary evidence suggests that lowering total cholesterol levels by diet may be an effective adjunctive therapy to statins, and raising plasma HDL-cholesterol concentrations among patients with coronary heart disease and low HDL-cholesterol levels ( < 1 mmol/l) by means of gemfibrozil may also effectively prevent stroke. In summary statin drugs are effective and safe in preventing initial and recurrent stroke.”

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

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

### **Stroke 7.2 Reporting and Verification**

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

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

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

### **Stroke Indicator 8**

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

### **Stroke 8.1 Rationale**

See Stroke 7.1.

### **Stroke 8.2 Reporting and Verification**

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

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

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

#### **Stroke Indicator 9**

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

#### **Stroke 9.1 Rationale**

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

*Grade A recommendation SIGN 13*

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

All patients who are not on anticoagulation should be taking aspirin (50-300mg) daily, or a combination of low-dose aspirin and dipyridamole modified release(MR). Where patients are aspirin-intolerant an alternative antiplatelet agent (clopidogrel 75mg daily or dipyridamole MR 200mg twice daily) should be used.

*Grade A Recommendation RCP Stroke Guideline*

Further Information:

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

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

*Grade A recommendation SIGN 13*

### **Stroke 9.2 Reporting and Verification**

Practices should report the percentage of patients with non-haemorrhagic stroke or TIA who have a record in the last 6 months of prescribed aspirin, clopidrogel, dipyridamole or warfarin or of taking OTC aspirin.

#### **Stroke Indicator 10**

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

### **Stroke 10.1 Rationale**

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

### **Stroke 10.2 Reporting and Verification**

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

## Hypertension

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

### Hypertension - Rationale for Inclusion of Indicator Set

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

#### **Hypertension (BP) Indicator 1**

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

#### **BP 1.1 Rationale**

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

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

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

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

*British Hypertension Society Guidelines 1999*

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

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

## **BP 1.2 Reporting and Verification**

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

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

### **Hypertension (BP) Indicator 2**

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

## **BP 2.1 Rationale**

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

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

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

Routine investigations should be limited to:

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

*British Hypertension Society Guidelines 1999*

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

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

A number of risk calculators are available at <http://www.wellclosesquare.co.uk/protocol/bhsgui/bhsgui.htm>

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

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

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

### **BP 2.2 Reporting and Verification**

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

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

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

### **BP 3.1 Rationale**

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

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

*Reference Grade B recommendation SIGN Guidelines 41/51*

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

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

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

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

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

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

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

<b>Hypertension (BP) Indicator 4</b>
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<b>The percentage of patients with hypertension in whom there is a record of the blood pressure in the past 9 months</b>
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### **BP 4.1 Rationale**

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

*British Hypertension Society Guidelines 1999*

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

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

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

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

<b>Hypertension (BP) Indicator 5</b>
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<b>The percentage of patients with hypertension in whom the last blood pressure (measured in the last 9 months) is 150/90 or less</b>
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#### **BP 5.1 Rationale**

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

#### **BP 5.2 Reporting and Verification**

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

#### **Diabetes Mellitus (Diabetes)**

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

<i>Indicator</i>	<i>Points</i>	<i>Payment Stages</i>
<b>Records</b>		
DM 1.The practice can produce a register of all patients with diabetes mellitus	6	

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

## Diabetes - Rationale for Inclusion of Indicator Set

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

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

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

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

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

<b>Diabetes (DM) Indicator 1</b>
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<b>The practice can produce a register of all patients with diabetes mellitus</b>
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### DM 1.1 Rationale

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

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

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

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

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

## **DM 1.2 Reporting and Verification**

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

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

<b>Diabetes (DM) Indicator 2</b>
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<b>The percentage of patients with diabetes whose notes record BMI in the previous 15 months</b>
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### **DM 2.1 Rationale**

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

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

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

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

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

### **DM 3.1 Rationale**

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

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

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

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

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

$$\frac{[no\ of\ never\ smoked] + [no\ recorded\ as\ ex- or\ current\ smokers\ in\ past\ 15\ months]}{[number\ with\ diabetes]}$$

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

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

#### **DM 4.1 Rationale**

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

*Grade A Recommendation SIGN 55*

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

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

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

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

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

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

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

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

#### **DM 5.1 Rationale**

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

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

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

*Grade D Recommendation NICE Inherited Guideline G*

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

## **DM 5.2 Reporting and Verification**

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

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

1. Inspection of the output from a computer search that has been used to provide information on this indicator
2. Inspection of a sample of records of patients with diabetes to look at the proportion with recorded HbA1c in last 15 months
3. Inspection of a sample of records of patients for whom a record of HbA1c is claimed, to see if there is evidence of this in the medical records.

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

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

## **DM 6.1 Rationale**

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

*Grade B Recommendation NICE Inherited Guideline G*

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

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

## **DM 6.2 Reporting and Verification**

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

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

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

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

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

## **DM 7.1 Rationale**

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

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

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

## **DM 7.2 Reporting and Verification**

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

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

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

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

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

## **DM 8.1 Rationale**

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

*Grade B Recommendation SIGN 55*

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

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

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

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

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

<b>Diabetes (DM) Indicator 9</b>
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<b>The percentage of patients with diabetes with a record of the presence or absence of peripheral pulses in the previous 15 months</b>
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### **DM 9.1 Rationale**

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

### **DM 9.2 Reporting and Verification**

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

<b>Diabetes (DM) Indicator 10</b>
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<b>The percentage of patients with diabetes with a record of neuropathy testing in the previous 15 months</b>
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### **DM 10.1 Rationale**

See DM 9.1

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

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

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

<b>Diabetes (DM) Indicator 11</b>
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<b>The percentage of patients with diabetes who have a record of the blood pressure in the past 15 months</b>
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### **DM 11.1 Rationale**

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

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

*Grade D Recommendation NICE Inherited Guideline H*

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

## **DM 11.2 Reporting and Verification**

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

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

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

## **DM 12.1 Rationale**

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

*Grade A Recommendation SIGN 55*

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

*Grade A Recommendation SIGN 55*

*Recommendation British Hypertension Society Guideline 1999*

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

*Grade D Recommendation SIGN 55*

*Recommendation British Hypertension Society Guideline 1999*

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

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

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

## **DM 12.2 Reporting and Verification**

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

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

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

## **DM 13.1 Rationale**

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

*Grade D Recommendation SIGN 55*

*Grade C Recommendation NICE Inherited Guideline F*

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

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

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

### **DM 13.2 Reporting and Verification**

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

#### **Diabetes (DM) Indicator 14**

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

### **DM 14.1 Rationale**

See DM 13.1

### **DM 14.2 Reporting and Verification**

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

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

1. Inspection of the output from a computer search that has been used to provide information on this indicator

2. Inspection of a sample of records of patients with diabetes to look at the proportion with recorded serum creatinine
3. Inspection of a sample of records of patients for whom a record of serum creatinine is claimed, to see if there is evidence of this in the medical records.

### **Diabetes (DM) Indicator 15**

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

#### **DM 15.1 Rationale**

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

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

*Grade A Recommendation SIGN 55*

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

#### **DM 15.2 Reporting and Verification**

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

## **Diabetes (DM) Indicator 16**

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

### **DM 16.1 Rationale**

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

*Grade C Recommendation SIGN Guideline 51*

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

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

### **DM 16.2 Reporting and Verification**

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

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

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

## **Diabetes (DM) Indicator 17**

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

### **DM 17.1 Rationale**

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

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

Further Information:

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

Mortality from Coronary Heart Disease in Subjects with Type 2 Diabetes and in Nondiabetic Subjects with and without Prior Myocardial Infarction  
Steven M. Haffner, M.D., Seppo Lehto, M.D., Tapani Rönnemaa, M.D., Kalevi Pyörälä, M.D., and Markku Laakso, M.D. *New England Journal of Medicine* 339:229-234

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

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

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

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

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

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

#### **DM 18.1 Rationale**

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

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

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

## **Chronic Obstructive Pulmonary Disease (COPD)**

<i>Indicator</i>	<i>Points</i>	<i>Payment Stages</i>
<b>Records</b>		
COPD 1. The practice can produce a register of patients with COPD	5	
<b>Initial diagnosis</b>		
COPD 2. The percentage of patients in whom diagnosis has been confirmed by spirometry including reversibility testing for newly diagnosed patients with effect from 1 April 2003	5	25-90%
COPD 3. The percentage of all patients with COPD in whom diagnosis has been confirmed by spirometry including reversibility testing	5	25-90%
<b>Ongoing management</b>		
COPD 4. The percentage of patients with COPD in whom there is a record of smoking status in the previous 15 months	6	25-90%
COPD 5. The percentage of patients with COPD who smoke, whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered in the past 15 months	6	25-90%
COPD 6. The percentage of patients with COPD with a record of FeV1 in the previous 27 months	6	25-70%
COPD 7. The percentage of patients with COPD receiving inhaled treatment in whom there is a record that inhaler technique has been checked in the preceding 2 years	6	25-90%
COPD 8. The percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March	6	25-85%

### **COPD - Rationale for Inclusion of Indicator Set**

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

The majority of patients with COPD are managed by general practitioners and members of the primary healthcare team with onward referral to secondary care when required. Consultation rates in patients with COPD are 2 to 4 times higher than the

equivalent rates for patients with angina. This indicator set focuses on the diagnosis and management of patients with symptomatic COPD.

### **COPD Indicator 1**

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

#### **COPD 1.1 Rationale**

A register is a prerequisite for monitoring patients with COPD.

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

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

See COPD 3.1.

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

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

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

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

## **COPD Indicator 2**

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

### **COPD 2.1 Rationale**

COPD is diagnosed if:

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

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

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

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

Further information:

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

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

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

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

## **COPD 2.2 Reporting and Verification**

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

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

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

### **COPD Indicator 3**

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

## **COPD 3.1 Rationale**

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

## **COPD 3.2 Reporting and Verification**

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

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

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

#### **COPD Indicator 4**

**The percentage of patients with COPD in whom there is a record of smoking status in the previous 15 months**

#### **COPD 4.1 Rationale**

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

*Grade A Evidence GOLD Guidelines*

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

There is no evidence relating to the frequency that smoking status should be recorded but it is important to promote cessation and continued abstinence. Smoking status should be reviewed annually.

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

The practice should report the percentage of patients on the COPD register in whom smoking status has been recorded in the last 15 months.

#### **COPD Indicator 5**

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

### **COPD 5.1 Rationale**

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

*Grade A Evidence GOLD Guideline*

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

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

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

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

### **COPD Indicator 6**

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

### **COPD 6.1 Rationale**

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

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

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

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

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

Grade A Evidence GOLD Guidelines

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

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

## **COPD 6.2 Reporting and Verification**

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

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

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

### **COPD Indicator 7**

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

#### **COPD 7.1 Rationale**

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

*BTS COPD Guidelines*

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

There is evidence that inhaled therapies can improve the quality of life in some patients with COPD. However, there is evidence that patients require training in inhaler technique and that such training requires reinforcement. There is no clear indication from the literature as to the required frequency of checking inhaler technique. A pragmatic view has been taken that this should be at least every two years.

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

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

### **COPD Indicator 8**

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

#### **COPD 8.1 Rationale**

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

## **COPD 8.2 Reporting and Verification**

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

### **Epilepsy**

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

### **Epilepsy - Rationale for Inclusion of Indicator Set**

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

#### **Epilepsy Indicator 1**

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

## **Epilepsy 1.1 Rationale**

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

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

## **Epilepsy 1.2 Reporting and Verification**

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

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

### **Epilepsy Indicator 2**

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

## **Epilepsy 2.1 Rationale**

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

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

- Seizure type and frequency, including date of last seizure
- Antiepileptic drug therapy and dosage
- Any adverse drug reactions arising from antiepileptic drug therapy

- Key indicators of the quality of care ie topics discussed and plans for future review

*Grade C Recommendation SIGN 21*

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

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

## **Epilepsy 2.2 Reporting and Verification**

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

### **Epilepsy Indicator 3**

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

## **Epilepsy 3.1 Rationale**

See Epilepsy 2.1

## **Epilepsy 3.2 Reporting and Verification**

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

## **Epilepsy Indicator 4**

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

### **Epilepsy 4.1 Rationale**

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

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

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

### **Epilepsy 4.2 Reporting and Verification**

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

### **Monitoring of Hypothyroidism**

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

### **Hypothyroidism - Rationale for Inclusion of Indicator Set**

Hypothyroidism is a common, serious condition with an insidious onset. The mean incidence is 3.5 per 1000 in women, and 0.6 per 1000 in men. The probability of

developing hypothyroidism increases with age and reaches 14 per 1000 in women aged between 75 and 80.

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

Monitoring of hypothyroidism is almost entirely undertaken in primary care.

### **Hypothyroid (THYROID) Indicator 1**

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

#### **Thyroid 1.1 Rationale**

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

#### **Thyroid 1.2 Reporting and Verification**

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

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

### **Hypothyroid (THYROID) Indicator 2**

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

#### **Thyroid 2.1 Rationale**

There is no clear evidence on the appropriate frequency of TSH/T4 measurement. However, the consensus group on thyroid disease recommended an annual check of TSH/T4 levels in all patients treated with thyroxine. In addition they recommend an annual check in patients previously treated with radio-iodine or partial thyroidectomy

(Consensus statement for good practice and audit measures in the management of hypothyroidism and hyperthyroidism. *BMJ* 1996;313:539-544).

## **Thyroid 2.2 Reporting and Verification**

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

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

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

## **Cancer**

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

## **Cancer - Rationale for Inclusion of Indicator Set**

Cancer is a clinical priority in all four countries.

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

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

This indicator set is not evidence-based.

### **Cancer Indicator 1**

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

#### **Cancer 1.1 Rationale**

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

#### **Cancer 1.2 Reporting and Verification**

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

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

### **Cancer Indicator 2**

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

#### **Cancer 2.1 Rationale**

Most general practitioners will see patients with a new cancer diagnosis following assessment and management in a secondary or tertiary care setting. The purpose of the review is usually to provide support to the patient and to ensure that follow-up arrangements between the GP and the secondary care service are clear both to the patient and the GP.

## Cancer 2.2 Reporting and Verification

The IT solution for this indicator is not straightforward. This is because it is difficult to tie the date of review to the date of diagnosis in computer searches.

Practices could search for patients who have been added to the register between 6 months and 12 months previously and undertake a manual search of notes to ascertain if a cancer review has been undertaken.

The alternative pragmatic solution which has been agreed is to undertake a search for those added to the cancer register between 6 and 12 months ago who also have an 8CLO coding in the last 12 months. Although this search is not identical to the indicator it will identify a cohort of cancer patients and identify if a cancer review has taken place up to twelve months after diagnosis dependent on when the diagnosis was made.

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

## Mental Health (MH)

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

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

months		
MH 5. The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the previous 6 months	5	25-70%

## **Mental Health - Rationale for Inclusion of Indicator Set**

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

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

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

### **Mental Health (MH) Indicator 1**

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

#### **MH 1.1 Rationale**

In order to carry out the reviews required below, it will be necessary to have a list of patients with severe long-term mental health problems. There are considerable difficulties around the diagnostic labelling of chronic mental illness. In the Quality and Outcomes Framework, unlike all the other clinical areas, we have not specified specific diagnostic labels to be used. The principle adopted is the construction of a register based on patient need.

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

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

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

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

## **MH 1.2 Reporting and Verification**

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

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

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

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

## **MH 2.1 Rationale**

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

A review of physical health will normally include:

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

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

In addition, an annual check is an opportunity to review co-ordination arrangements with secondary care, eg for details of CPN and other services to be recorded in the notes, and to summarise what services are actually being received. This information can be invaluable if the patient presents to the GP with a deterioration in his or her condition.

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

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

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

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

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

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

#### **MH 3.1 Rationale**

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

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

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

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

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

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

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

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

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

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

## **MH 4.1 Rationale**

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

## **MH 4.2 Reporting and Verification**

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

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

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

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

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

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

## **MH 5.1 Rationale**

See MH 3.1

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

## MH 5.2 Reporting and Verification

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

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

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

## Asthma

<i>Indicator</i>	<i>Points</i>	<i>Payment stages</i>
<b>Records</b>		
ASTHMA 1. The practice can produce a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the last twelve months	7	
<b>Initial Management</b>		
ASTHMA 2. The percentage of patients aged eight and over diagnosed as having asthma from 1 April 2003 where the diagnosis has been confirmed by spirometry or peak flow measurement	15	25-70%
<b>Ongoing management</b>		
ASTHMA 3. The percentage of patients with asthma between the ages of 14 and 19 in whom there is a record of smoking status in the previous 15 months	6	25-70%
ASTHMA 4. The percentage of patients aged 20 and over with asthma whose notes record smoking status in the past	6	25-70%

15 months, except those who have never smoked where smoking status should be recorded at least once		
ASTHMA 5. The percentage of patients with asthma who smoke, and whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered within the last 15 months	6	25-70%
ASTHMA 6. The percentage of patients with asthma who have had an asthma review in the last 15 months	20	25-70%
ASTHMA 7. The percentage of patients aged 16 years and over with asthma who have had influenza immunisation in the preceding 1 September to 31 March	12	25-70%

### **Asthma - Rationale for Inclusion of Indicator Set**

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

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

#### **Asthma Indicator 1**

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

#### **Asthma 1.1 Rationale**

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

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

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

#### **Adults**

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

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

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

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

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

## **Children**

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

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

The diagnosis of asthma in children should be based on:

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

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

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

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

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

### **Asthma 1.2 Reporting and Verification**

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

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

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

#### **Asthma Indicator 2**

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

### **Asthma 2.1 Rationale**

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

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

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

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

#### **Asthma Indicator 3**

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

### **Asthma 3.1 Rationale**

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

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

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

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

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

#### **Asthma Indicator 4**

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

#### **Asthma 4.1 Rationale**

See asthma 3.1

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

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

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

$$\begin{aligned} & \% \text{ with smoking status recorded (among patients with asthma aged 20 and over)} = \\ & \frac{[\text{no of never smoked}] + [\text{no recorded as ex- or current smokers in past 15 months}]}{[\text{number with asthma aged 20 and over}]} \end{aligned}$$

#### **Asthma Indicator 5**

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

#### **Asthma 5.1 Rationale**

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

Many strategies have been used to help people to stop smoking. A meta-analysis of controlled trials in patients post myocardial infarction showed that a combination of

individual and group smoking cessation advice, and assistance reinforced on multiple occasions - initially during cardiac rehabilitation and reinforced by primary care teams - gave the highest success rates.

*Reference Grade B recommendation SIGN Guidelines 41/51*

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

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

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

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

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

## **Asthma 5.2 Reporting and Verification**

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

<b>Asthma Indicator 6</b>
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<b>The percentage of patients with asthma who have had an asthma review in the last 15 months</b>
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## **Asthma 6.1 Rationale**

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

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

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

"In the last month

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

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

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

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

**Summary of Asthma Review:**

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

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

### **Asthma 6.2 Reporting and Verification**

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

**Asthma Indicator 7**

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

**Asthma 7.1 Rationale**

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

**Asthma 7.2 Reporting and Verification**

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

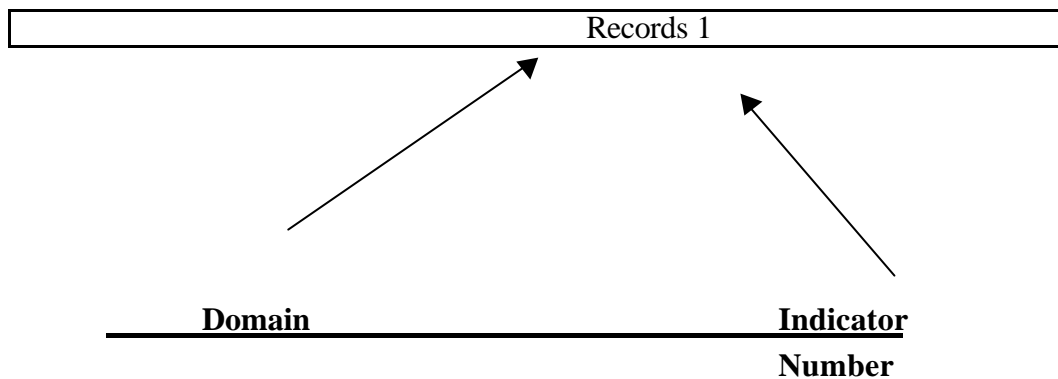
## **SECTION 3: ORGANISATIONAL INDICATORS**

### **1. Format**

Organisational indicators are split into five domains:

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

**Indicators are numbered as follows:**



For each indicator (x) four descriptions are given:

### **X.1 Practice guidance**

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

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

### **X.2 Written evidence**

This specifies the written evidence which a practice would be expected to produce for an assessment visit. The evidence generally should be available in the practice and need not be submitted in advance. However, some written evidence will be required

in advance and this is indicated in the document. In some instances no written evidence will be required but may be requested if there is an appeal.

In summary, written evidence is categorised as follows:

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

### **X.3 Assessment visit**

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

### **X.4 Assessors' guidance**

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

## **2. Equivalence – Other Schemes**

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

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

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

### **Summary of Indicators**

<b>Records 1 1 point</b>	Each patient contact with a clinician is recorded in the patient's record, including consultations, visits and telephone advice
<b>Records 2 1 point</b>	Entries in the records are legible
<b>Records 3</b>	The practice has a system for transferring and acting on information about patients

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

**Records Indicator 1**

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

**Records 1.1 Practice guidance**

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

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

Records can be on paper or on computer.

**Records 1.2 Written evidence**

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

**Records 1.3 Assessment visit**

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

**Records 1.4 Assessors' guidance**

If a patient phones for advice, how is this recorded in the notes?

All patient contacts need to be recorded.

**Records Indicator 2**

**Entries in the records are legible**

**Records 2.1 Practice guidance**

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

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

### **Records 2.2 Written evidence**

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

### **Records 2.3 Assessment visit**

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

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

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

## **Records Indicator 3**

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

### **Records 3.1 Practice guidance**

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

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

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

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

### **Records 3.2 Written evidence**

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

### **Records 3.3 Assessment visit**

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

### **Records 3.4 Assessors' guidance**

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

<b>Records Indicator 4</b>
<b>There is a reliable system to ensure that messages and requests for visits are recorded and that the appropriate doctor or team member receives and acts upon them</b>

### **Records 4.1 Practice guidance**

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

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

### **Records 4.2 Written evidence**

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

### **Records 4.3 Assessment visit**

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

### **Records 4.4 Assessors' guidance**

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

### **Records Indicator 5**

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

### **Records 5.1 Practice guidance**

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

### **Records 5.2 Written evidence**

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

### **Records 5.3 Assessment visit**

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

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

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

## **Records Indicator 6**

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

### **Records 6.1 Practice guidance**

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

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

### **Records 6.2 Written evidence**

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

### **Records 6.3 Assessment visit**

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

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

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

## **Records Indicator 7**

**The medicines that a patient is receiving are clearly listed in his or her record**

### **Records 7.1 Practice guidance**

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

This indicator applies to all prescriptions, acute and repeat, but only repeat prescriptions will be assessed.

If the computer is used for issuing and recording repeat prescriptions then this criterion is easily achieved.

If paper records only are kept, then a separate sheet may be kept as one method of listing the repeat medication.

### **Records 7.2 Written evidence**

The practice should describe how prescribed medication is recorded. (Grade C)

### **Records 7.3 Assessment visit**

A search of patient records might be conducted.

### **Records 7.4 Assessors' guidance**

Drug therapy refers to repeat medication as far as the assessment is concerned.

## **Records Indicator 8**

**There is a designated place for the recording of drug allergies and adverse reactions in the notes and these are clearly recorded**

### **Records 8.1 Practice guidance**

It is important that a clinician avoids prescribing a drug to which the patient is known to be allergic. Not all patients can recall this information and hence records of allergies are important.

All prescribing clinicians should know where such information is recorded. Ideally the place where this information is recorded should be limited to one place and not more than two places.

### **Records 8.2 Written evidence**

There should be a statement as to where drug allergies are recorded. (Grade C)

### **Records 8.3 Assessment visit**

The practice should be able to demonstrate where drug allergies are recorded.

## **Records 8.4 Assessors' guidance**

The place where drug allergies are recorded can be on the computer or in the paper records. This information should be easily available to the prescribing clinician at the time of consultation.

### **Records Indicator 9**

**For repeat medicines, an indication for the drug can be identified in the records (for drugs added to the repeat prescription with effect from 1 April 2004)**

**Minimum Standard 80%**

## **Records 9.1 Practice guidance**

When reviewing medication, it is important to know why a drug was started. This information in the past has often been difficult to identify in GP records, particularly if a patient has been on a medication for a long time or has transferred between practices. It is proposed that this information needs to be recorded clearly in the clinical records.

It is recognised that most practices utilise computer systems for repeat prescriptions and it is intended that an IT solution will be available to assist practices in meeting this indicator. The start date for this indicator has therefore been delayed to 1 April 2004 as not all GP clinical IT systems can link diagnosis to repeat prescriptions. A system for doing this will need to be initiated in many practices when the software has been modified. This criterion will not be assessed until after 1 April 2004.

In practices where the computer is not utilised for repeat prescriptions, the clinician should write clearly in the patient record the diagnosis relating to the prescription. This need only be done once when the medication is initiated.

The survey to show compliance should be a minimum of 50 patients who have been commenced on a new repeat prescription from 1 April 2004.

## **Records 9.2 Written evidence**

A survey of the drugs used should be carried out. The survey should show an indication can be identified for at least 80% of repeat medications commenced after 1<sup>st</sup> April 2004. (Grade A)

### ***Records 9.3 Assessment visit***

The records should be inspected.

### **Records 9.4 Assessors' guidance**

As part of the inspection of records those drugs which have been added to the repeat prescription from 1 April 2004 should be identified and an indication for starting them should be clear. The help of practice staff may be required to achieve this. The records of twenty patients for whom repeat medication has been started since that date should be surveyed. If the standard is not achieved then a further twenty clinical records should be surveyed and the cumulative total should be used. The minimum standard is that 80% of the indications for repeat medication drugs can be identified.

### **Records Indicator 10**

**The smoking status of patients aged from 15 to 75 is recorded for at least 55% of patients**

### **Records 10.1 Practice guidance**

There is evidence that when doctors and other health professionals advise patients to stop smoking, this is effective. This indicator examines whether smoking status is recorded in the clinical record.

Dependent on how practices record smoking status, the survey can be undertaken by computer search or a survey of the written records.

Although smoking status recorded ever is sufficient to fulfil this criterion, it is good practice to ask smokers their status on a regular basis.

A similar indicator is proposed as Records Indicator 16 but a higher standard must be achieved.

### **Records 10.2 Written evidence**

A survey of written records or a computer search of patients aged from 15 to 75 years should be carried out (surveying a minimum of 50 records), to determine the percentage where smoking habit is recorded at least once. (Grade A)

### **Records 10.3 Assessment visit**

A random sample of 20 notes or computerised records of patients aged from 15 to 75 should be inspected, to confirm that smoking status is recorded at least once.

## **Records 10.4 Assessors' guidance**

The practice's own survey is verified by inspecting 20 patient records at the visit. If the result differs from the practice survey then a further 20 patient records should be checked.

### **Records Indicator 11**

**The blood pressure of patients aged 45 and over is recorded in the preceding 5 years for at least 55% of patients**

## **Records 11.1 Practice guidance**

Detecting elevated blood pressure and treating it is known to be an effective health intervention. The limit to patients aged 45 and over has been pragmatically chosen as the vast majority of patients develop hypertension after this age. It is anticipated that practices will opportunistically check blood pressures in all adult patients.

Depending on whether practices record blood pressure in the computer or manual record, the survey can be undertaken by computer search or a survey of the written records.

A similar indicator is proposed as Records Indicator 17 but a higher standard must be achieved.

## **Records 11.2 Written evidence**

A survey of the records of patients aged 45 and over (a minimum of 50 records) or a report from a computer search should be carried out, showing that blood pressure has been recorded in last 5 years. (Grade A)

## **Records 11.3 Assessment visit**

A random sample of 20 notes or computerised records of patients aged 45 and over should be inspected, to confirm that blood pressure has been recorded in last 5 years.

## **Records 11.4 Assessors' guidance**

The practice's own survey may be verified by inspecting 20 clinical records of patients aged 45 and over at the visit. If the result differs from the practice survey, then a further 20 records need to be checked.

## **Records Indicator 12**

**When a member of the team prescribes a medicine, there is a mechanism for that prescription to be entered into the patient's general practice record**

### **Records 12.1 Practice guidance**

Nurse prescribing is increasing and expanding. It is important that all prescribed medicines are recorded in the clinical record. This should include all medications prescribed by any team member.

Useful references are 'Nurse Prescribing: a guide for implementation' 1998 [concerning district nurse/health visitor prescribing] and 'Extending Independent Nurse Prescribing within the NHS in England: a guide for implementation' March 2002 [concerning extended formulary nurse prescribing].

### **Records 12.2 Written evidence**

There should be a statement as to how prescriptions are recorded, and in particular how nurse-initiated prescriptions are recorded. (Grade C).

### **Records 12.3 Assessment visit**

A sample of records should be inspected.

### **Records 12.4 Assessors' guidance**

Nurse prescribers should be questioned on the system for entering prescriptions in patients' records and the system should be checked with any other members of the team involved.

## **Records Indicator 13**

**There is a system to alert the out-of-hours service or duty doctor to patients dying at home**

### **Records 13.1 Practice guidance**

Good Medical Practice states that when off duty the doctor ensures there are arrangements which "include effective hand-over procedures and clear communication between doctors". It is especially important for patients who are terminally ill and likely to die in the near future at home or where clinical management is proving difficult or challenging.

The practice should have developed a system with their out-of-hours care provider to transfer information from the practice to that provider about patients that the attending doctor anticipates may die from a terminal illness in the next few days and hence may require medical services in the out-of-hours period. If a practice does its own on call duties then a system should ensure that all doctors in the practice are aware of these patients. A single-handed doctor who usually covers his or her own patients out of hours should have a similar system in place when he or she is absent from the practice eg on holiday.

### **Records 13.2 Written evidence**

The system for alerting the out-of-hours service or duty doctor to patients dying at home should be described. (Grade C)

### **Records 13.3 Assessment visit**

The doctors in the practice should be questioned on the system that is in place.

### **Records 13.4 Assessors' guidance**

The team should be questioned on their system by asking for recent examples of patients who have been terminally ill, dying at home and what information was passed to the out-of-hours service or duty doctor.

### **Records Indicator 14**

**The records, hospital letters and investigation reports are filed in date order or available electronically in date order**

**Minimum Standard 80%**

### **Records 14.1 Practice guidance**

Good Medical Practice for General Practitioners states that the excellent doctor “files GP notes, hospital letters, and investigation reports in date order”.

Any combination of paper and computer records is allowable.

### **Records 14.2 Written evidence**

A survey of patient records (minimum 50) should be carried out, recording the percentage of records, hospital letters and investigations are filed in date order. A minimum of 80% is to be achieved. (Grade A)

### **Records 14.3 Assessment visit**

A random sample of 20 clinical records should be examined to confirm the percentage of records in which the hospital letters and investigations are filed in date order.

### **Records 14.4 Assessors' guidance**

The practice's own survey is verified by inspecting 20 clinical records. If the result differs from the practice survey then a further 20 records need to be checked.

## **Records Indicator 15**

**The practice has up-to-date clinical summaries in at least 60% of patient records**

### **Records 15.1 Practice guidance**

Good Medical Practice for General Practitioners states "Important information in records should be easily accessible, for example, as part of a summary."

If a system for producing summaries is not in place then this will involve a great deal of work. The practice will need to decide which conditions it will include in the summary. The practice would be expected to have a policy on what is included in a summary. All significant past and continuing problems should be included.

If a computer is used the practice will need to decide which Read codes to use for common conditions. It is best to use a set of codes that has been agreed within a PCO or nationally to allow comparison and exchange of data.

A similar indicator is proposed as Records 18 but a higher standard must be achieved.

### **Records 15.2 Written evidence**

A survey of patient records (minimum 50) should be carried out, recording the percentage that have clinical summaries and the percentage which are up to date. (Grade A)

### **Records 15.3 Assessment visit**

A random sample of 20 patient records should be examined to confirm the percentage that have clinical summaries and the percentage which are up to date.

#### **Records 15.4 Assessors' guidance**

The practice's own survey is verified by inspecting 20 clinical records. If the result differs from the practice survey then a further 20 records need to be checked. Assessors may need to clarify with the practice what information they would normally include in a clinical summary ensuring that they do not assess this indicator based on their own experience and beliefs.

#### **Records Indicator 16**

**The smoking status of patients aged from 15 to 75 is recorded for at least 75% of patients**

#### **Records 16.1 Practice guidance**

See Records 10.1.

#### **Records 16.2 Written evidence**

See Records 10.2. (Grade A)

#### **Records 16.3 Assessment visit**

See Records 10.3.

#### **Records 16.4 Assessors' guidance**

See Records 10.4.

#### **Records Indicator 17**

**The blood pressure of patients aged 45 and over is recorded in the preceding 5 years for at least 75% of patients**

**Records 17.1 Practice guidance**

See Records 11.1.

**Records 17.2 Written evidence**

See Records 11.2. (Grade A)

**Records 17.3 Assessment visit**

See Records 11.3.

**Records 17.4 Assessors' guidance**

See Records 11.4.

**Records Indicator 18**

**The practice has up-to-date clinical summaries in at least 80% of patient records**

**Records 18.1 Practice guidance**

See Records 15.1.

**Records 18.2 Written evidence**

See Records 15.2. (Grade A)

**Records 18.3 Assessment visit**

See Records 15.3.

## **Records 18.4 Assessors' guidance**

See Records 15.4.

### **Records Indicator 19**

**80% of newly registered patients have had their notes summarised within 8 weeks of receipt by the practice**

## **Records 19.1 Practice guidance**

The criterion refers to the time the notes have been received by the practice and not the time of registration. For some practices that take on many patients at a set time of year achievement of the indicator will require some forward planning.

Read codes may be utilised to record this information and can then be searched for on the practice computer system.

## **Records 19.2 Written evidence**

A survey should be carried out of the records of newly registered patients whose notes have been received between 8 and 26 weeks previously (either a sample of 30 or all patients if there have been fewer than 30 such registrations), noting if the records have been received and summarised.

Alternatively a computer print-out should be examined, showing the patients registered where the records have been received between 8 and 26 weeks previously, to confirm whether the computer record contains a clinical summary. (Grade A)

## **Records 19.3 Assessment visit**

A sample of 20 records of patients whose records were sent to the practice between by the PCO between 9 and 26 weeks ago should be examined, to ascertain if the records have arrived and have been summarised.

## **Records 19.4 Assessors' guidance**

A list of patients registered in the past 12 months and whose records have been forwarded between 9 and 26 weeks ago to the practice will be obtained from the

PCO. A sample of 20 records, or all if there have been fewer of these patients, will be checked. If the result differs significantly (at least 10%) from the practice survey a further 20 records will be checked if appropriate.

## **Organisational Indicators – Information for Patients (B)**

### **Summary of Indicators**

<b>B. Information for Patients</b>	
<b>Information 1 0.5</b>	The practice has a system to allow patients to contact the out-of-hours service by making no more than two telephone calls
<b>Information 2 0.5 points</b>	If an answering system is used out of hours, the message is clear and the contact number is given at least twice
<b>Information 3 1 point</b>	The practice has arrangements for patients to speak to GPs and nurses on the telephone during the working day
<b>Information 4 1 point</b>	If a patient is removed from a practice's list, the practice provides an explanation of the reasons in writing to the patient and information on how to find a new practice, unless it is perceived that such an action would result in a violent response by the patient
<b>Information 5 2 points</b>	The practice supports smokers in stopping smoking by a strategy which includes providing literature and offering appropriate therapy
<b>Information 6 0.5 points</b>	Information is available to patients on the roles of the GP, community midwife, health visitor and hospital clinics in the provision of ante-natal and post-natal care
<b>Information 7 1.5 points</b>	Patients are able to access a receptionist via telephone and face to face in the practice, for at least 45 hours over 5 days, Monday to Friday, except where agreed with the PCO
<b>Information 8 1 point</b>	The practice has a system to allow patients to contact the out-of-hours service by making no more than one telephone call

#### **Information Indicator 1**

**The practice has a system to allow patients to contact the out-of-hours service by making no more than two telephone calls**

#### **Information 1.1 Practice guidance**

In an emergency, it is important that a patient can contact a clinician quickly. This was a recommendation of out-of-hours reviews in both Scotland and England.

A practice should ensure that its system does not include any additional telephone calls for patients to make over and above the two calls stated in the indicator. This may be particularly relevant in areas where contacting the duty doctor may involve phoning the practice, then the doctor's home, and then a mobile phone number.

### **Information 1.2 Written evidence**

The system for contacting the out-of-hours service should be described. (Grade C)

### **Information 1.3 Assessment visit**

The practice should be telephoned after 6.30 pm on a weekday, or at some other time during the out-of-hours period.

### **Information 1.4 Assessors' guidance**

The practice should be telephoned after 6.30 pm on a weekday, or at some other time during the out-of-hours period, to confirm that no more than two telephone calls are needed to contact the out-of-hours service. This confirmation will need to have taken place prior to the visit.

### **Information Indicator 2**

**If an answering system is used out of hours, the message is clear and the contact number is given at least twice**

### **Information 2.1 Practice guidance**

It is useful for the answering system message to be clearly posted near the telephone so that all staff are aware of the approved wording. This minimises the risk of staff re-recording the message and changing the agreed format. Patients with hearing impairment find messages with background noise, eg ringing phones etc, difficult to hear. Staff or doctors should be encouraged to speak slowly when recording the message. This indicator will only be assessed if an answering system is used.

If the practice does not use the answer machine then it would be exempt from this indicator.

### **Information 2.2 Written evidence**

The practice will state the exact message used. (Grade C)

### **Information 2.3 Assessment visit**

The answering system will be demonstrated.

### **Information 2.4 Assessors' guidance**

The assessor should listen to the message in order to confirm that background noise on the tape does not obscure the message and that the number is clear and repeated at least twice. This can be checked along with Information Indicator 1.

### **Information Indicator 3**

**The practice has arrangements for patients to speak to GPs and nurses on the telephone during the working day**

### **Information 3.1 Practice guidance**

Good Medical Practice for General Practitioners states that the excellent GP “has a system for receiving or returning phone calls from patients” and that the unacceptable GP “provides no opportunity for patients to talk to a doctor or a nurse on the phone”.

Some practices have specific times to speak to a clinician and others make arrangements for the clinician to phone the patient back.

It is useful for this information to be advertised to patients eg through the practice leaflet, notices in the practice, slips given to patients when being asked to phone back for a result, the tear-off side of a prescription, the practice newsletter etc.

### **Information 3.2 Written evidence**

The practice has a written policy on telephone availability (Grade A)

### **Information 3.3 Assessment visit**

The assessors should seek out evidence on when the practice team is available to answer telephone calls by checking practice leaflets, observing the office and asking reception and clinical staff.

### **Information 3.4 Assessors’ guidance**

The receptionists should be able to respond positively to a request by a patient to speak to a clinician on the telephone. The assessors should confirm with reception staff the information they give patients who require to speak to a GP or practice-employed nurse. Patients do not require to speak to a clinician immediately unless it is an emergency, but at least one clinician in the practice should be available every working day. The assessors should confirm with staff how patients are informed of the policy and check the stated sources, eg practice leaflet, notices at the reception desk or in the waiting area, etc.

### **Information Indicator 4**

**If a patient is removed from the practice’s list, the practice provides an explanation of the reasons in writing to the patient and information on how to find a new practice, unless it is perceived that such an action would result in a violent response by the patient**

#### **Information 4.1 Practice guidance**

It is good practice to explain to a patient the reasons for being removed from the list. This is the recommendation of both the BMA and the RCGP. Normally, this will be based on a perceived breakdown in the doctor/patient relationship but it will often be useful to give a fuller explanation than simply stating this. The letter should not normally be a standard letter of removal but tailored to the individual situation. The reason for removal should not be solely that a patient has made a complaint against the practice (see Good Medical Practice for General Practitioners).

Many patients will not be aware of the procedure for registration with another practice and will not be aware that the Primary Care Organisation can assist them. They should be given relevant guidance and contact details.

In exceptional circumstances, it will be felt that a written explanation of the reasons for removal for the list will further inflame a difficult situation, potentially endangering the safety of practice team members. In these circumstances, the omission of a written explanation will be justified. It may be useful to discuss this issue and include guidance in the practice's policy.

#### **Information 4.2 Written evidence**

There should be a written policy on removing patients from the list. (Grade B)

#### **Information 4.3 Assessment visit**

The written policy statement should be inspected or the practice team should be questioned on the policy.

#### **Information 4.4 Assessors' guidance**

The practice should submit a written policy. It may also be useful to check with team members that the policy is consistently used. Patients should normally be given a written reason for their removal and the letter should contain both the elements in the criterion.

#### **Information Indicator 5**

**The practice supports smokers in stopping smoking by a strategy which includes providing literature and offering appropriate therapy**

#### **Information 5.1 Practice guidance**

There is good evidence about the effectiveness of healthcare professionals in assisting patients to stop smoking.

A number of studies have recently shown benefits from the prescription of nicotine replacement therapy or bupropion in patients who have indicated a wish to quit smoking.

Further Information: <http://www.nice.org.uk/pdf/NiceNRT39GUIDANCE.pdf>

The strategy does not need to be written by the practice team. A local or national protocol could be adapted for use specifically by the practice and implemented. The provision of dedicated smoking cessation services remains the responsibility of the PCO.

### **Information 5.2 Written evidence**

There should be a practice protocol concerning smoking cessation. (Grade A)

### **Information 5.3 Assessment visit**

Prescribing data should be reviewed, and literature available for patients who wish to quit should be examined.

### **Information 5.4 Assessors' guidance**

The strategy should take into account current evidence in this area. Signs of implementation may be evident in the practice's prescribing data or in the patient leaflets that are used by the practice.

## **Information Indicator 6**

**Information is available to patients on the roles of the GP, community midwife, health visitor and hospital clinics in the provision of ante-natal and post-natal care**

### **Information 6.1 Practice guidance**

The provision of information to patients which clearly defines the roles of the team members involved in their care will contribute to their satisfaction with the service and help them to use it appropriately. It is particularly useful if the information can name the individuals who may be involved in the patient's care.

### **Information 6.2 Written evidence**

The practice gives ante-natal patients written information on the roles of each member of the practice team. (Grade B)

### **Information 6.3 Assessment visit**

The information given to ante-natal patients should be inspected.

## **Information 6.4 Assessors' guidance**

The availability of copies of information given to ante-natal patients should be checked with team members.

### **Information Indicator 7**

**Patients are able to access a receptionist via telephone and face to face in the practice, for at least 45 hours over 5 days, Monday to Friday, except where agreed with the PCO**

## **Information 7.1 Practice guidance**

Good Medical Practice for General Practitioners states “patients appreciate being able to contact the surgery throughout the working day.” To satisfy this indicator, reception staff will have to be available face to face and on the telephone for the stated hours, spread through Monday to Friday. This indicator may be difficult and inappropriate to satisfy in some single-handed and remote and rural practices. In these circumstances, the level of receptionist cover should be agreed with the PCO. The practice should have written confirmation that this level of cover has been agreed.

## **Information 7.2 Written evidence**

There should be a written summary of the times when telephone/face-to-face access to receptionists is available. (Grade A)

## **Information 7.3 Assessment visit**

Reception staff should be questioned concerning the arrangements for access to receptionists.

## **Information 7.4 Assessors' guidance**

Assessors should confirm with reception staff that their hours of work as a team cover the hours of telephone and face-to-face availability as stated in the summary. In single-handed or remote and rural practices where it is not appropriate or possible to provide this amount of cover, the practice should have available written confirmation from the PCO of the agreed level of coverage.

### **Information Indicator 8**

**The practice has a system to allow patients to contact the out-of-hours service by making no more than one telephone call**

## **Information 8.1 Practice guidance**

This is an aspiration of the Carson report on out-of-hours care in England. The Scottish review on out-of-hours services also recommends that, ideally, those services should be contactable by making no more than one telephone call.

It is recognised that this may put an additional burden on out-of-hours services and the introduction of this indicator will be linked to the movement of responsibility for out-of-hours care to PCOs in April 2004.

The ability to do this will depend on the technology available. If this is not available in a practice area, then exemption may be applied for from the PCO.

Practices should ensure that their system does not include a requirement that patients should make additional telephone calls over and above the one call stated in the criterion. This may be particularly relevant in areas where contacting the duty doctor may involve phoning the practice, then the doctor's home, and then being passed to a mobile phone number. If, in order to satisfy this indicator, the practice has to leave another number on the answering system, please refer also to Information Indicator 2 regarding the quality of the message.

#### **Information 8.2 Written evidence**

No written evidence is required.

#### **Information 8.3 Assessment visit**

The practice should be telephoned after 6.30 pm.

#### **Information 8.4 Assessors' guidance**

The practice should be telephoned after 6.30 pm to confirm that no more than one telephone call is needed to contact the out-of-hours service. This phone call should take place prior to the visit. Exemptions agreed by the PCO will need to be specified in writing.

## **Organisational Indicators – Education and Training (C)**

### **Summary of Indicators**

<b>Education 1 4 points</b>	There is a record of all practice-employed clinical staff having attended Training/updating in basic life support skills in the preceding 18 months
<b>Education 2 4 points</b>	The practice has undertaken a minimum of six significant event reviews in the past 3 years
<b>Education 3 2 points</b>	All practice-employed nurses have an annual appraisal
<b>Education 4 3 points</b>	All new staff receive induction training
<b>Education 5 3 points</b>	There is a record of all practice-employed staff having attended training/updating in basic life support skills in the preceding 36 months
<b>Education 6 3 points</b>	The practice conducts an annual review of patient complaints and suggestions to ascertain general learning points which are shared with the team
<b>Education 7 4 points</b>	The practice has undertaken a minimum of twelve significant event reviews in the past 3 years which include (if these have occurred): <ul style="list-style-type: none"> <li>• Any death occurring in the practice premises</li> <li>• Two new cancer diagnoses</li> <li>• Two deaths where terminal care has taken place at home</li> <li>• One patient complaint</li> <li>• One suicide</li> <li>• One section under the Mental Health Act</li> </ul>
<b>Education 8 3 points</b>	All practice-employed nurses have personal learning plans which have been reviewed at annual appraisal
<b>Education 9 3 points</b>	All practice-employed non-clinical team members have an annual appraisal

#### **Education Indicator 1**

**There is a record of all practice-employed clinical staff having attended training/updating in basic life support skills in the preceding 18 months**

#### **Education 1.1 Practice guidance**

The primary care team members deal with cardio-pulmonary collapse relatively rarely, but require to have up-to-date skills to deal with an emergency. This is best undertaken at regular intervals through practical skills-based training sessions, as it is

known that these skills diminish after a relatively short time. The timescale has been set pragmatically at 18 months, although many practices offer training on a more frequent basis.

This training may be available from a variety of providers including your local Accident and Emergency Department, BASICS, the PCO, out-of-hours co-operative, Red Cross, St John's Ambulance or equivalent. It may be sufficient for one individual in the team to attend for external training and then cascade this within the team.

### **Education 1.2 Written evidence**

Attendance at CPR training should be listed. (Grade B)

### **Education 1.3 Assessment visit**

Staff should be questioned on the date of their last CPR training.

### **Education 1.4 Assessors' guidance**

Assessors should confirm by checking the CPR attendance list that practice-employed clinical staff have attended.

## **Education Indicator 2**

**The practice has undertaken a minimum of six significant event reviews in the past 3 years**

### **Education 2.1 Practice guidance**

Significant event review is a recognised methodology for reflecting on important events within a practice and is an accepted process as evidence for GMC revalidation.

Significant event analysis is not new, although its terminology may have changed. It was first known as critical event monitoring. It provides structure to an activity which anyway happens informally between health care professionals. It is the discussion of cases and events and the learning obtained through reflection. Due to its reflective nature, it can be viewed as an extension of audit activity. Discussion of specific events can provoke emotions that can be harnessed to achieve change. For it to be effective, it needs to be practised in a culture that avoids blame allocation and involves all disciplines within the practice.

The following steps are useful in introducing significant event analysis to a practice:

1. A multidisciplinary meeting to explain the concept.
2. Consideration of events which should be important to the practice but need not imply criticism of the practice. The practice can construct a core list as a basis to stimulate discussion or it can use the one published in the RCGP Occasional

Paper (see reference at end of this section). Some of the examples from this are below.

Preventative care:	Measles Unplanned pregnancy Non-accidental injury Squint diagnosed by an ophthalmologist
Acute care:	Sudden unexpected death Death occurring on the practice premises Suicide or suicide attempt All new cancer diagnoses Myocardial Infarction Terminal care death at home Section under Mental Health Act
Chronic disease:	Diabetic hypoglycaemia Leg ulcer or amputation Asthma - hospitalisation Epilepsy – status epilepticus
Organisation:	Investigation received but not acted upon Breach of confidentiality Any patient complaints Upsetting of staff

3. Mechanism for identification of events. A logbook kept at reception may be helpful or an electronic logbook held on the practice computer system. Any mechanism should allow all team members to contribute.
4. Significant events meetings. These are generally multidisciplinary but need not be so and are chaired. Notes should be taken but should not include patient identification. Each attendee should be encouraged to take along at least one significant event. The meeting can choose which to discuss first and anybody can have the right to veto if that area is considered too sensitive.

The events are then discussed, first highlighting the aspects of high standard and then those standards that can be improved. A decision about the case needs to be reached.

This can be:

- celebration of excellent care
- no change
- audit required
- Immediate change required.

Follow-up of these decisions should be arranged and this may occur at the next significant event analysis meeting.

These reports should be laid out in a form consistent with either of the two following suggested formats:

A.

- **Description of event.** This should be brief and can be in note form.
- **Learning outcome.** This should describe the aspects which were of high standard and those which could be improved. Where appropriate it should include why the event occurred.
- **Action plan.** The decision(s) taken need to be contained in the report. The reasons for these decisions should be described together with any other lessons learned from the discussion.

B.

- What happened?
- Why did it happen?
- Was insight demonstrated?
- Was change implemented?

Reference:

Royal College of General Practitioners. *Significant Event Auditing: Occasional Paper 70*. London: RCGP, 1995.

A description of significant event audit is also available in: Robinson LA, Stacy R, Spencer JA, Bhopal RS. *How To Do It: Use facilitated case discussions for significant event auditing*. *BMJ* 1995; 311: 315-318.

## **Education 2.2 Written evidence**

Each case report must consist of a short commentary setting out the relevant history, the circumstances of the episode and an analysis of the conclusions to be drawn. Evidence should be presented of any clinical and organisational changes resulting from the analysis of these cases. (Grade A)

## **Education 2.3 Assessment visit**

The reviews should be discussed.

## **Education 2.4 Assessors' guidance**

The practice should report their analyses in a form consistent with either of the two following methods:

- A. Statement of the problem or event, learning outcome and action plan OR
- B. What happened? Why did it happen? Was insight demonstrated? Was change implemented?

The practice should involve, where ever possible, all team members who were stakeholders in the event in the case discussion.

### **Education Indicator 3**

#### **All practice-employed nurses have an annual appraisal**

##### **Education 3.1 Practice guidance**

Appraisal is a constructive opportunity to review performance objectives, progress and skills and identify learning needs in a protected environment. The learning needs identified may be personal to the appraisee and/or organisational learning needs which the appraisee has agreed to fulfil. The outcome of the appraisal should be a written action plan agreed between appraiser and appraisee which could include a personal learning plan for the appraisee.

Practices which have established appraisal schemes for the nursing team use varying professionals as appraisers. The agreed structure of the scheme should include identification of which individual(s) will take on the role of appraiser. It is important that all team members who are appraisers are adequately trained in appraisal techniques.

Some further guidance on appraisal can be found on the ACAS website ([www.acas.org.uk](http://www.acas.org.uk)) and in the ACAS advisory booklet: Employee Appraisal. <http://www.acas.org.uk/publications/B07.html>

The practice could draw on the professional practice and appraisal skills of a lead nurse in the PCO.

##### **Education 3.2 Written evidence**

The appraisal system should be described. (Grade C)

##### **Education 3.3 Assessment visit**

The doctors and practice-employed nurses should be questioned on the nurses' appraisals.

##### **Education 3.4 Assessors' guidance**

The appraisal system for practice-employed nurses should be discussed with the nurses themselves and the person responsible for managing the appraisal scheme eg GPs, nurse, practice manager. The appraisal content is confidential and should not be discussed at the visit.

### **Education Indicator 4**

#### **All new staff receive induction training**

##### **Education 4.1 Practice guidance**

The use of a structured induction programme will help new staff fit more quickly into the practice and support them in becoming effective team members. It is useful to establish a programme of induction for a post, but to remember that it may need to be used flexibly, for example when an employee:

- is returning to work after a long absence
- has not worked before
- has a disability
- is from an ethnic minority group.

A programme could include:

- going through terms and conditions of employment
- meeting other members of the practice team, possibly including shadowing
- clarifying areas of responsibility and accountability
- practice codes and/or standards and regulations including Health and Safety/special hazards, uniforms, arrangements for working overtime, time in lieu etc
- familiarisation with protocols and procedures including employment procedures eg sickness absence policy
- training in the responsibilities of the post.

This list is not exhaustive.

Clear recording of the areas covered in the programme and regular reviews of progress will help establish the standard of performance which is expected and help the manager and new member of staff to identify remaining areas of lack of knowledge and understanding. This will help the new team member to feel valued and supported.

#### **Education 4.2 Written evidence**

If a new member of staff has commenced after 1 April 2003, a copy of the induction programme which has been implemented should be available. (Grade B)

#### **Education 4.3 Assessment visit**

The induction programme should be inspected.

#### **Education 4.4 Assessors' guidance**

**It may be useful to speak to the newest member of staff as well as inspecting the induction programme itself if he or she has commenced in post after 1 April 2003.**

<b>Education Indicator 5</b>
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<b>There is a record of all practice-employed staff having attended training/updating in basic life support skills in the preceding 36 months</b>
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### **Education 5.1 Practice guidance**

Although it is rare for practice non-clinical staff to have to deal with a cardio-pulmonary collapse, the situation may arise within or outwith the practice premises.

See Education 1.

The interval for training is pragmatically set at three years although many practices offer training on a more frequent basis.

### **Education 5.2 Written evidence**

Attendance at CPR training should be listed. (Grade B)

### **Education 5.3 Assessment visit**

Staff should be questioned on the date of their last CPR training.

### **Education 5.4 Assessors' guidance**

Confirmation that practice non-clinical staff have attended training should be obtained by checking the CPR attendance list.

<b>Education Indicator 6</b>
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<b>The practice conducts an annual review of patient complaints and suggestions to ascertain general learning points which are shared with the team</b>
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### **Education 6.1 Practice guidance**

Practices and clinicians generally find complaints stressful. It is important that the practice view complaints as a potential source for learning and for change and development.

Reports should include a summary of each complaint or suggestion and an identification of any learning points which came out of the review. It may be useful to agree at the time of each review how the learning points or areas for change will be communicated to the team; it is likely that not all team members will be involved in every review meeting for various reasons. It will also be useful to identify an individual responsible for implementing the change and monitoring its progress.

These reports may form part of the written evidence for the indicators on significant event analysis (Education 2 and Education 7).

### **Education 6.2 Written evidence**

Reports/minutes of team meetings where learning points have been discussed should be made, with a note of the changes made as a result. (Grade A)

### **Education 6.3 Assessment visit**

The issue of learning from complaints should be discussed with staff and doctors.

### **Education 6.4 Assessors' guidance**

Assessors should discuss with team members their involvement in reviews of patient complaints and suggestions and how the learning points are shared with the team.

### **Education Indicator 7**

**The practice has undertaken a minimum of twelve significant event reviews in the past 3 years which include (if these have occurred):**

- **Any death occurring in the practice premises**
- **Two new cancer diagnoses**
- **Two deaths where terminal care has taken place at home**
- **One patient complaint**
- **One suicide**
- **One section under the Mental Health Act**

### **Education 7.1 Practice guidance**

Detail of methodology on significant event analysis is given in Education 2.

This indicator is more prescriptive in the requirement to report on specific occurrences in the practice. Clearly if certain of these events have not occurred, eg patient suicide, then this should be stated in the evidence.

### **Education 7.2 Written evidence**

Each review case report must consist of a short commentary setting out the relevant history, the circumstances of the episode and an analysis of the conclusions to be drawn. Evidence should be presented of any clinical and organisational changes resulting from the analysis of these cases. (Grade A)

### **Education 7.3 Assessment visit**

The reviews should be discussed.

### **Education 7.4 Assessors' guidance**

The practice should report on its analyses in a form consistent with either of the two methods described in Education 2.

**Education Indicator 8**

**All practice-employed nurses have personal learning plans which have been reviewed at annual appraisal**

**Education 8.1 Practice guidance**

The production of a personal learning plan may be one of the outcomes of the appraisal system. The plan could record the agreement between appraiser(s) and appraisee on areas for further learning, how they will be achieved, who is responsible for organising them, within what timescale, and how progress will be reviewed. It may also include learning areas which have been identified as an organisational need but which have been agreed at the appraisal as an individual development area for the appraisee to take forward. This information should be recorded.

**Education 8.2 Written evidence**

The staff appraisal system should be described. (Grade C)

**Education 8.3 Assessment visit**

A discussion should be held with practice-employed nursing staff about their personal learning plans.

**Education 8.4 Assessors' guidance**

Personal learning plans should be discussed with practice-employed nursing staff.

**Education Indicator 9**

**All practice-employed non-clinical team members have an annual appraisal**

**Education 9.1 Practice guidance**

Appraisal is a constructive opportunity to review performance objectives, progress and skills and identify learning needs in a protected environment. The learning needs identified may be personal to the appraisee and/or organisational learning needs which the appraisee has agreed to fulfil. The outcome of the appraisal should be a written action plan agreed between appraiser and appraisee which could include a personal learning plan for the appraisee. In addition the opportunity could be taken to review and update the appraisee's job description.

**Education 9.2 Written evidence**

The staff appraisal system should be described. (Grade C)

**Education 9.3 Assessment visit**

A discussion should be held with practice-employed non-clinical staff about their experience of appraisal.

**Education 9.4 Assessors' guidance**

It may be useful to discuss the appraisal system with the non-clinical staff themselves, the practice manager and the GPs.

## **Organisational Indicators – Practice Management (D)**

### Summary of Indicators

	D. Practice Management
<b>Management 1 1 point</b>	Individual healthcare professionals have access to information on local procedures relating to Child Protection
<b>Management 2 1.5 points</b>	There are clearly defined arrangements for backing up computer data, back-up verification, safe storage of back-up tapes and authorisation for loading programmes where a computer is used
<b>Management 3 0.5 points</b>	The Hepatitis B status of all doctors and relevant practice-employed staff is recorded and immunisation recommended if required in accordance with national guidance
<b>Management 4 1 point</b>	The arrangements for instrument sterilisation comply with national guidelines as applicable to primary care
<b>Management 5 3 points</b>	The practice offers a range of appointment times to patients, which as a minimum should include morning and afternoon appointments five mornings and four afternoons per week, except where agreed with the PCO
<b>Management 6 2 points</b>	Person specifications and job descriptions are produced for all advertised vacancies
<b>Management 7 3 points</b>	The practice has systems in place to ensure regular and appropriate inspection, calibration, maintenance and replacement of equipment including: <ul style="list-style-type: none"> <li>• A defined responsible person</li> <li>• Clear recording</li> <li>• Systematic pre-planned schedules</li> <li>• Reporting of faults</li> </ul>
<b>Management 8 1 point</b>	The practice has a policy to ensure the prevention of fraud and has defined levels of financial responsibility and accountability for staff undertaking financial transactions (accounts, payroll, drawings, payment of invoices, signing cheques, petty cash, pensions, superannuation etc.)
<b>Management 9 3 points</b>	The practice has a protocol for the identification of carers and a mechanism for the referral of carers for social services assessment
<b>Management 10 4 points</b>	There is a written procedures manual that includes staff employment policies including equal opportunities, bullying and harassment and sickness absence (including illegal drugs, alcohol and stress), to which staff have access

#### **Management Indicator 1**

**Individual healthcare professionals have access to information on local procedures relating to Child Protection**

### **Management 1.1 Practice guidance**

Awareness of the existence of local Child Protection procedures is mandatory and all healthcare professionals should be able to access a copy.

### **Management 1.2 Written evidence**

There should be a description of how local procedures are accessed. (Grade C)

### **Management 1.3 Assessment visit**

Access to local procedures should be demonstrated.

### **Management 1.4 Assessors' guidance**

The assessors should check with team members what action they would take if they had reason to suspect that a child might be being abused, including which local procedures they would refer to and how.

### **Management Indicator 2**

**There are clearly defined arrangements for backing up computer data, back-up verification, safe storage of back-up tapes and authorisation for loading programmes where a computer is used**

### **Management 2.1 Practice guidance**

The practice should have a written policy which defines who is responsible for backing up data, how it is done and how often it is done. It is good practice to keep weekly and monthly backups as well as daily backups using a rotation of back-up tapes or their equivalent. It is good practice to keep a log. Tapes should be renewed at specified intervals. Verification of backups should also be carried out at regular specified intervals, especially in paper-light or paperless practices. Tapes should be stored in a fireproof safe, with a procedure in place for back-up tapes being stored off site in order to ensure confidentiality. The policy should also define the individuals who are authorised to load new software programmes.

### **Management 2.2 Written evidence**

There should be written policy regarding:

- backing up data and verification, including the frequency of that back-up
- storage on and off site

- authorisation to load programmes. (Grade A)

### **Management 2.3 Assessment visit**

The back-up and loading arrangements should be demonstrated.

### **Management 2.4 Assessors' guidance**

The arrangements for back-up, verification and storage procedures should be checked with the responsible staff member. It is important to ascertain that staff are aware of the procedure for authorisation for loading new software.

### **Management Indicator 3**

**The Hepatitis B status of all doctors and relevant practice-employed staff is recorded and immunisation recommended if required in accordance with national guidance**

### **Management 3.1 Practice guidance**

Useful guidance on Hepatitis B risks and immunisation is contained in the UK Health Departments' publication "Guidance for Clinical Health Care Workers: protection against infection with blood borne viruses – recommendations of the Expert Advisory Group on AIDS and the Advisory Group on Hepatitis" ([www.doh.gov.uk/pub/docs/doh/chcguidl.pdf](http://www.doh.gov.uk/pub/docs/doh/chcguidl.pdf)). The BMA supplies an interactive CD ROM "Bloodborne viruses and infection control: a guide for health care professionals". (1998) This also provides access to the Health Department's guidance mentioned above.

Under the Health and Safety at Work etc Act (1974) (HSWA), GPs are legally obliged to make sure that all employees receive appropriate training and know the procedures for working safely. They must also carry out risk assessments and these could include assessing procedures under the Control of Substances Hazardous to Health Regulations 1994 (COSHH). These regulations would cover employees who have direct contact with patients' blood, other potentially infectious bodily fluids or tissues. Immunisation of doctors and staff that have direct contact with these substances is recommended in the above regulations.

The Health Department guidance "Protecting health care workers and patients from Hepatitis B" and the 1996 addendum (see above reference to the website, Annex 1) states that all health care workers who perform exposure prone procedures (EPPs) should be immunised. They should have their response to the vaccine checked and non-responders to vaccination should be investigated for infection in order to minimise risk to patients. This guidance also states that workers whose Hepatitis B status is unknown should be tested before carrying out EPPs.

Immunisation provides protection in up to 90% of patients vaccinated, but is not a substitute for good infection control procedures.

The BMA website provides a specimen Hepatitis B immunisation policy in the general practice staff (non-medical) specimen handbook. Advice on suitable immunisation policies can also be obtained from the Occupational Health Service, which works with reference to guidelines published in “Immunisation against Infectious Disease” (see Annex 1 in the above website).

In relation to confidentiality, the BMA Website offers the following guidance:

“It is extremely important that hepatitis B infected health care workers have the same right of confidentiality as any patient seeking or receiving medical care. Occupational health notes are separate from other hospital notes and occupational health physicians are ethically and professionally obliged not to release information without the consent of the individual. There are occasions when an employer may need to be advised that a change of duties should take place, but hepatitis B status itself will not normally be disclosed without the health care worker's consent. However, where patients are, or have been, at risk of exposure to hepatitis B from an infected healthcare worker, it may be necessary in the public interest for the employer to have access to confidential information”.

### **Management 3.2 Written evidence**

There should be evidence that the Hepatitis B status of all staff is known. (Grade C)

### **Management 3.3 Assessment visit**

Questioning should take place on the system to check Hepatitis B status.

### **Management 3.4 Assessors' guidance**

It should be confirmed that evidence is available that the Hepatitis B status of all doctors and relevant practice-employed staff has been recorded and that there is a mechanism for recommending (and recording any recommendation) regarding vaccination to the doctor or staff member, including checking response to vaccination.

## **Management Indicator 4**

**The arrangements for instrument sterilisation comply with national guidelines as applicable to primary care**

### **Management 4.1 Practice guidance**

The Health Departments in each Country will issue guidance relating to instrument sterilisation which will be agreed with the General Practitioners Committee.

### **Management 4.2 Written evidence**

There must be a policy for instrument sterilisation.

### **Management 4.3 Assessment visit**

The sterilisation arrangements should be inspected.

### **Management 4.4 Assessors' guidance**

Definitive guidance is yet to be finalised with the departments of health.

### **Management Indicator 5**

**The practice offers a range of appointment times to patients, which as a minimum should include morning and afternoon appointments five mornings and four afternoons per week, except where agreed by the PCO**

### **Management 5.1 Practice guidance**

In practices which operate with open surgeries, this would mean that the practice should have a range of times of availability equivalent to the appointment range in the indicator. Patients should be offered a reasonable range of appointment times, which are advertised to them. The practice's appointment system should normally offer as a minimum the range of appointments described in the practice leaflet. In remote and rural areas, for example, or in some single-handed practices, the range of appointment availability described in the indicator will not be appropriate. In these circumstances, the practice should agree its availability with the PCO and this should be advertised in the practice leaflet. Evidence that this has been agreed should be made available to the assessor.

### **Management 5.2 Written evidence**

The practice leaflet should be scrutinised for evidence of appointment times. (Grade A)

### **Management 5.3 Assessment visit**

The practice leaflet and appointment book should be checked.

### **Management 5.4 Assessors' guidance**

The advisers should check that the practice advertises in the practice leaflet a range of appointment times which corresponds to the indicator. The availability of such appointments should be confirmed by looking at a randomly selected week in the appointment book/appointment system. In practices offering a more limited range of appointment availability, the practice should provide evidence that the PCO has agreed the range on offer.

### **Management Indicator 6**

**Person specifications and job descriptions are produced for all advertised vacancies**

### **Management 6.1 Practice guidance**

Production of a person specification and job description at the time of identifying a vacancy not only ensures that the practice maximises its chances of employing the right person for the job, but protects the practice against the risk of being in breach of the following acts: the Sex Discrimination Act, Equal Pay Act, Disability Discrimination Act and Race Relations Act. The government is currently working on draft legislation covering discrimination on the grounds of sexual orientation, religion and age. It is also good practice not to discriminate on these grounds during the recruitment process.

Useful guidance on how to recruit without discrimination can be found on the following web sites:

- The Equal Opportunities Commission Code of Practice – Sex Discrimination at [www.eoc.org.uk](http://www.eoc.org.uk). If unsuccessful candidates for a post were to claim that they had been discriminated against on the grounds of sex, then they could take their complaint to an employment tribunal. The tribunal would take into account whether the Code of Practice was relevant to the circumstances of the case and, if so, failure by the practice to follow the code would be taken into consideration in its determination. The ACAS website also gives guidance on Equal Opportunities ([www.acas.org.uk](http://www.acas.org.uk)).
- The Disability Discrimination Act: Code of Practice for the elimination of discrimination in the field of employment against disabled persons or persons who have had a disability at [www.disability.gov.uk](http://www.disability.gov.uk) or [www.drc-gb.org/drc/Documents/copemployment.doc](http://www.drc-gb.org/drc/Documents/copemployment.doc). This Code of Practice applies to employers with 15 or more employees. This threshold excluding small firms will be reviewed. The Code explains the Act in the form of answering frequently asked questions and clearly explains employers' obligations. It covers advertising, the selection process, terms and conditions of service and "reasonable adjustments".
- The Commission for Race Equality: Employment Code of Practice at: [www.cre.gov.uk/gdpract//employ\\_cop\\_1.html](http://www.cre.gov.uk/gdpract//employ_cop_1.html).  
The Code of Practice covers advertising, selection/shortlisting, uniforms, language and other areas.

### **Management 6.2 Written evidence**

The person specification and job description of the last person employed after 1 April 2003 should be available. (Grade B)

### **Management 6.3 Assessment visit**

The assessment should involve questioning on the person specification and job description of the last person employed after 1 April 2003.

#### **Management 6.4 Assessors' guidance**

The assessors should check that the practice's approach to recruitment has included production of a person specification and job description relevant to the actual vacancy. Discussion could include the process used for drawing up the person specification eg who was involved and the opportunity for reviewing the job description. The practice could demonstrate understanding of how the production of the specification and job description demonstrates good employment practice.

#### **Management Indicator 7**

**The practice has systems in place to ensure regular and appropriate inspection, calibration, maintenance and replacement of equipment including:**

- **A defined responsible person**
- **Clear recording**
- **Systematic pre-planned schedules**
- **Reporting of faults**

#### **Management 7.1 Practice guidance**

The evidence for this criterion may form part of the statutory risk assessment activity which takes place under the Health and Safety at Work Regulations 1999 (Management Regulations). Comprehensive guidance on risk assessment can be found in the Health and Safety Executive's website on [www.hse.gov.uk](http://www.hse.gov.uk). The website provides a free booklet "Five steps to risk assessment".

This website also contains a free leaflet "Maintaining portable electrical equipment in offices and other low risk environments". This contains guidance on the appropriate person to inspect and maintain equipment in relation to the equipment's associated risks as well as suggested intervals between inspections and maintenance. For example, a printer may be inspected and maintained by a "competent" person with enough knowledge and training, who need not be an electrician. This is only one of several free leaflets available on the website; others may also be relevant to the individual practice's circumstances.

The schedule should clearly identify who has overall responsibility, who is the appropriate individual to inspect/maintain/calibrate each piece of equipment, the intervals between inspections and the system for reporting faults.

### **Management 7.2 Written evidence**

Details should be given of the system to ensure regular and appropriate inspection, calibration, maintenance and replacement of equipment meeting the stated criteria. (Grade B)

### **Management 7.3 Assessment visit**

A review of equipment requiring maintenance and of the log of inspection and maintenance should be undertaken.

### **Management 7.4 Assessors' guidance**

The practice should have in place a system which includes risk assessment of equipment and a schedule of inspection, calibration and maintenance. This should include electrical equipment.

The responsible person will not always be the person actually carrying out the inspection; this should be specified in the schedule.

The intervals between inspection, calibration and maintenance will be different for various types of equipment dependent on their associated level of risk. Inspection, calibration and maintenance should be recorded.

There should be a clear system for reporting faults.

The practice should be able to provide a written record of inspection, calibration and maintenance for some randomly selected pieces of equipment. It would be useful to consider a range of equipment from small items (eg printer) up to larger items such as a steriliser or defibrillator.

### **Management Indicator 8**

**The practice has a policy to ensure the prevention of fraud and has defined levels of financial responsibility and accountability for staff undertaking financial transactions (accounts, payroll, drawings, payment of invoices, signing cheques, petty cash, pensions, superannuation, etc.)**

### **Management 8.1 Practice guidance**

The practice should have a policy which clearly defines the levels of financial responsibility in the practice. This will include a description of the activities which are carried out by the practice manager (eg payroll), other staff (eg petty cash) and partners (eg calculation of drawings) and will make clear the extent of responsibility. For example, the senior receptionist may be responsible for managing the petty cash on a day-to-day basis and may produce a monthly statement for the practice manager along with handing over cash for banking. The practice manager may then be

responsible for checking this and for recording and banking the cash. The practice manager may have overall responsibility for ensuring the management of the petty cash.

The line of accountability for finance in the practice should also be clearly defined. For example, a particular partner may be identified as being responsible on behalf of the partnership for financial management. This responsibility may be delegated to the practice manager, who may have responsibility for day to day book-keeping, banking and other record-keeping, reconciling the bank statements and preparing regular financial statements for the finance partner. The finance partner will then be responsible to the partnership as a whole.

A fraud prevention policy may cover the following areas:

- a defined partner is responsible with the practice manager for business and finance affairs
- bank accounts are only operable with at least two signatories. The number of non-partners who are signatories should be restricted
- the same individual should where ever possible not be both payee and authorising signatory
- the practice should avoid undue reliance on one member of staff for financial and business controls
- staff are never paid in cash for work undertaken
- there is a written procedure for the removal of cash from petty cash
- all income and expenditure are recorded and reconciled with the bank statement
- purchases of equipment etc are only made with the prior approval of a partner – a level of expenditure may be agreed and set above which approval should be sought
- all transfers between accounts are properly authorised and can be substantiated
- all cheques signed should be accompanied by appropriate documentation eg invoice
- the practice should ensure where possible that one individual does not place an order, authorise the invoice and sign the cheque.

### **Management 8.2 Written evidence**

The policy is provided. (Grade A)

### **Management 8.3 Assessment visit**

Questioning is carried out on the steps taken to prevent fraud.

### **Management 8.4 Assessors' guidance**

The practice's fraud prevention policy is discussed with the practice manager and the partner(s) with financial responsibility.

### **Management Indicator 9**

**The practice has a protocol for the identification of carers and a mechanism for the referral of carers for social services assessment**

### **Management 9.1 Practice guidance**

The practice should produce a procedure for how carers are identified and a referral protocol to social services for assessment and carers with specific needs.

### **Management 9.2 Written evidence**

The protocol is available. (Grade A)

### **Management 9.3 Assessment visit**

The policy is discussed.

### **Management 9.4 Assessors' guidance**

The assessors should enquire of various team members what action they would take when they identify that a carer may benefit from social services involvement.

### **Management Indicator 10**

**There is a written procedures manual that includes staff employment policies including equal opportunities, bullying and harassment and sickness absence (including illegal drugs, alcohol and stress), to which staff have access**

## **Management 10.1 Practice guidance**

It is good employment practice to have established written procedures, which are available to staff, so that both staff and employer are clear about the steps to be taken if a problem arises. As well as the policies mentioned, the manual could include the Disciplinary and Grievance Procedure.

Useful guidance on writing these policies can be found as follows:

- Equal Opportunities Policy: The Equal Opportunities Commission – Guidelines for Equal Opportunities Employers on [www.eoc.org.uk/EOCeng/EOCcs/Advice/guidelines.asp](http://www.eoc.org.uk/EOCeng/EOCcs/Advice/guidelines.asp). Guidance can also be found on the ACAS web site on [www.acas.org.uk](http://www.acas.org.uk). This information can also be obtained from ACAS Reader Ltd, PO Box 16, Earl Shilton, Leicester LE9 8ZZ (tel 01455 852225). The Department for Education and Skills also publishes an Equal Opportunities Ten Point Plan for Employers giving practical advice on implementing equal opportunities policies.
- Bullying and Harassment: ACAS as above.
- IHM Healthcare Management Code at [ihm.org.uk](http://ihm.org.uk).
- IHM Diversity Group recommendations for Recruitment and Selection.
- Sickness Absence: ACAS as above, including their booklet entitled “Absence and Labour Turnover”.
- BMA guidance on managing absence at [bma.org.uk](http://bma.org.uk).

## **Management 10.2 Written evidence**

Employment policies should be recorded. (Grade B). Policies should be consistent with current legislation and indicate a date when the policy has been reviewed.

## **Management 10.3 Assessment visit**

The procedures manual should be inspected.

## **Management 10.4 Assessors’ guidance**

The procedures manual should contain dated copies which are made available to staff of the policies relating to their employment. It should be confirmed with employed staff that they are aware of the content of the procedures manual and its whereabouts.

## **Organisational Indicators – Medicines Management (E)**

### Summary of Indicators

<b>Medicines 1 2 points</b>	Details of prescribed medicines are available to the prescriber at each surgery consultation
<b>Medicines 2 2 points</b>	The practice possesses the equipment and in-date emergency drugs to treat anaphylaxis
<b>Medicines 3 2 points</b>	There is a system for checking the expiry dates of emergency drugs on at least a daily basis
<b>Medicines 4 3 points</b>	The number of hours from requesting a prescription to availability for collection by the patient is 72 hours or less (excluding weekends and bank/local holidays)
<b>Medicines 5 7 points</b>	A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed four or more repeat medicines Standard 80%
<b>Medicines 6 4 points</b>	The practice meets the PCO prescribing adviser at least annually and agrees up to three actions related to prescribing
<b>Medicines 7 4 points</b>	Where the practice has responsibility for administering regular injectable neuroleptic medication, there is a system to identify and follow up patients who do not attend
<b>Medicines 8 6 points</b>	The number of hours from requesting a prescription to availability for collection by the patient is 48 hours or less (excluding weekends and bank/local holidays)
<b>Medicines 9 8 points</b>	A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed repeat medicines Standard 80%
<b>Medicines 10 4 points</b>	The practice meets the PCO prescribing adviser at least annually, has agreed up to three actions related to prescribing and subsequently provided evidence of change

### **Medicines Indicator 1**

**Details of prescribed medicines are available to the prescriber at each surgery consultation**

### **Medicines 1.1 Practice guidance**

It is important that all prescribers are aware of what prescribed medication the patient is taking.

The practice should ensure this information is available to nurses when they are consulting and prescribing as well as to doctors.

### **Medicines 1.2 Written evidence**

There should be a description of where prescribed medication is recorded. (Grade C)

### **Medicines 1.3 Assessment visit**

The records/computer system should be inspected.

### **Medicines 1.4 Assessors' guidance**

This indicator refers to nurse prescribers as well as doctors but does not refer to home visits.

<b>Medicines Indicator 2</b>
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<b>The practice possesses the equipment and in-date emergency drugs to treat anaphylaxis</b>
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### **Medicines 2.1 Practice guidance**

Good Medical Practice for General Practitioners states that the excellent doctor “has up-to-date emergency equipment and drugs” and anaphylaxis is one condition that may constitute an emergency in the practice premises.

### **Medicines 2.2 Written evidence**

There is a list of equipment and drugs that the practice has available to deal with an anaphylactic emergency. (Grade C)

### **Medicines 2.3 Assessment visit**

The appropriate equipment and drugs are inspected.

### **Medicines 2.4 Assessors' guidance**

The dates of emergency drugs should be checked.

**Medicines Indicator 3**

**There is a system for checking the expiry dates of emergency drugs on at least an annual basis**

**Medicines 3.1 Practice guidance**

Good Medical Practice for General Practitioners states that the unacceptable GP “has drugs which are out of date” and a system is required to prevent this. The system should include all emergency drugs held in the practice premises and in the doctors’ bags.

**Medicines 3.2 Written evidence**

The system is described. (Grade C)

**Medicines 3.3 Assessment visit**

A random sample of doctors’ bags and other emergency drugs is checked.

**Medicines 3.4 Assessors’ guidance**

All drugs should be in date and the doctors should be questioned on the system for keeping them up to date.

**Medicines Indicator 4**

**The number of hours from requesting a prescription to availability for collection by the patient is 72 hours or less (excluding weekends and bank/local holidays)**

**Medicines 4.1 Practice guidance**

Practices should provide a reasonably fast service for their repeat prescriptions. Details of how the practice’s system works should be contained in the practice leaflet.

If the practice can deliver the service in 48 hours, another indicator is also achieved (Indicator Med 8).

#### **Medicines 4.2 Written evidence**

The practice leaflet or policy is available. ( Grade A)

#### **Medicines 4.3 Assessment visit**

The receptionists are questioned on the policy.

#### **Medicines 4.4 Assessors' guidance**

The assessors should check that the system for issuing repeat prescriptions can be described by the receptionists and should observe it in action.

#### **Medicines Indicator 5**

**A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed four or more repeat medicines  
Standard 80%**

#### **Medicines 5.1 Practice guidance**

A review of medication allows an opportunity for the clinician to assess the continuing need for medication with the patient. Additionally, the condition itself for which the medication is prescribed may require monitoring as well as the medication itself. The review may not always necessarily be a face-to-face review. It is possible to review the patient's repeat prescriptions in some circumstances without seeing the patient face to face eg by telephone review or a review of the records.

The survey will show the number of patients with four or more repeat medications and the percentage who have had a medication review in the last 15 months.

A doctor, nurse prescriber or pharmacist may conduct the review.

There is a corresponding indicator which requires that all patients on repeat medication should be reviewed.

### **Medicines 5.2 Written evidence**

A survey of medication review should be undertaken. (Grade A) This could be a computerised search and print out or a survey of fifty records of patients on four or more medications.

### **Medicines 5.3 Assessment visit**

Inspection of a sample of records of patients receiving repeat medication for four or more medications should be carried out.

### **Medicines 5.4 Assessors' guidance**

The assessors should ask the staff to demonstrate how the system works and in particular how an annual review is ensured.

<b>Medicines Indicator 6</b>
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<b>The practice meets the PCO prescribing adviser at least annually and agrees up to three actions related to prescribing</b>
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### **Medicines 6.1 Practice guidance**

If the PCO prescribing adviser is unable to visit within the year and there has been no contact with another PCO-recognised source of prescribing advice within the year, then the practice is exempt from this indicator. In that circumstance, the practice should provide written confirmation from the PCO prescribing adviser that he or she has been unable to visit within the relevant year.

### **Medicines 6.2 Written evidence**

Three actions agreed with the PCO prescribing adviser should be produced, or written confirmation from the PCO prescribing adviser that he or she has been unable to visit within the relevant year. (Grade A)

### **Medicines 6.3 Assessment visit**

The actions should be discussed.

### **Medicines 6.4 Assessors' guidance**

This indicator will be considered to have been met if the prescribing adviser and the practice have reached agreement on the action points.

### **Medicines Indicator 7**

**Where the practice has responsibility for administering regular injectable neuroleptic medication, there is a system to identify and follow up patients who do not attend**

### **Medicines 7.1 Practice guidance**

The consequences of patient default from this system are serious. It is therefore important that the practice's follow-up system is efficient and reliable. However, because of the relatively low number of patients in this group, a simple manual system will often be effective. If the practice has the opportunity for involving a CPN in the patient follow-up system, this can contribute significantly.

### **Medicines 7.2 Written evidence**

The system should be described. (Grade C)

### **Medicines 7.3 Assessment visit**

The assessors should question the practice team on whether they have patients on injectable neuroleptic medication and ask them to demonstrate the system for identifying and following up those who do not attend.

#### **Medicines 7.4 Assessors' guidance**

If the patient receives his or her injections from a hospital team that is responsible for this care, then the practice does not need to include those patients who receive their injection in this way in their system. This for example would apply in relation to a CPN who reports to the mental health team rather than to the practice.

#### **Medicines Indicator 8**

**The number of hours from requesting a prescription to availability for collection by the patient is 48 hours or less (excluding weekends and bank/local holidays)**

#### **Medicines 8.1 Practice guidance**

Patients tend to prefer a reasonably fast service for their repeat prescriptions. Details of how the practice's system works should be contained in the practice leaflet. If the practice can achieve this in 72 hours, then another indicator is achieved (Medicines Indicator 4).

#### **Medicines 8.2 Written evidence**

The practice leaflet or policy is available. (Grade A)

#### **Medicines 8.3 Assessment visit**

The receptionists are questioned on the policy.

#### **Medicines 8.4 Assessors' guidance**

The assessors should check that the system for issuing repeat prescriptions can be described by the receptionists and should observe it in action.

## **Medicines Indicator 9**

**A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed repeat medicines Standard 80%**

### **Medicines 9.1 Practice guidance**

A review of medication allows an opportunity for the clinician to assess the continuing need for a medication with the patient. Additionally, the condition itself for which the medication is prescribed may require monitoring as well as the medication itself. The review may not always necessarily be a face-to-face review. It is possible to review the patient's repeat prescriptions in some circumstances without seeing the patient face to face e.g. by telephone review or a review of the records.

Another indicator requires that medication should be reviewed for all patients being prescribed four or more repeat medications (Medicines Indicator 5).

### **Medicines 9.2 Written evidence**

A survey of medication reviews should be undertaken. (Grade A) This could be a computerised search and print out or a survey of fifty records of patients on four or more medications.

### **Medicines 9.3 Assessment visit**

Inspection of records should be carried out.

### ***Medicines 9.4 Assessors' guidance***

The assessors should ask the staff to demonstrate how the system works and in particular how an annual review is ensured.

**Medicines Indicator 10**

**The practice meets the PCO prescribing adviser at least annually, has agreed up to three actions related to prescribing and subsequently provided evidence of change**

**Medicines 10.1 Practice guidance**

Normally, improvements should be demonstrated in all three areas. However, if good reasons can be presented by the practice for not having achieved improvements, then the practice can still achieve this indicator. The practice should be able to provide written support from the PCO prescribing adviser for its reasons for not achieving the areas in question.

If the PCO prescribing adviser is unable to visit within the year, then the practice is exempt. The practice should provide written confirmation from the PCO prescribing adviser that he or she has been unable to visit within the relevant year.

**Medicines 10.2 Written evidence**

Three actions agreed with the PCO prescribing adviser and evidence of change should be produced, and/or written support from the prescribing adviser for the reasons for not achieving change, or written confirmation from the PCO prescribing adviser that he or she has been unable to visit within the relevant year. (Grade A)

**Medicines 10.3 Assessment visit**

Actions and improvements should be discussed.

**Medicines 10.4 Assessors' guidance**

Normally, improvements should be demonstrated in all three areas. However, if good reasons can be presented by the practice for not having achieved improvements, then the practice can still achieve this indicator. The practice should be able to provide written support from the PCO prescribing adviser for its reasons for not achieving the areas in question.

## Section 4: Patient Experience

<b>PE Patient Experience</b>
<b>PE 1 Length of Consultations</b>  The length of routine booked appointments with the doctors in the practice is not less than 10 minutes. [If the practice routinely sees extras during booked surgeries, then the average booked consultation length should allow for the average number of extras seen in a surgery session. If the extras are seen at the end, then it is not necessary to make this adjustment.]  For practices with only an open surgery system, the average face-to-face time spent by the GP with the patient is at least 8 minutes.  Practices that routinely operate a mixed economy of booked and open surgeries should report on both criteria.
<b>PE 2 Patient Surveys (1)</b>  The practice will have undertaken an approved patient survey each year.
<b>PE 3 Patient Surveys (2)</b>  The practice will have undertaken a patient survey each year, have reflected on the results and have proposed changes if appropriate.
<b>PE 4 Patient Surveys (3)</b>  The practice will have undertaken a patient survey each year and discussed the results as a team and with either a patient group or Non-Executive Director of the PCO. Appropriate changes will have been proposed with some evidence that the changes have been enacted.

<b>PE 1 Length of Consultations</b>  The length of routine booked appointments with the doctors in the practice is not less than 10 minutes. If the practice routinely sees extras during booked surgeries, then the average booked consultation length should allow for the average number of extras seen in a surgery session. If the extras are seen at the end, then it is not necessary to make this adjustment.  For practices with only an open surgery system, the average face-to-face time spent by the GP with the patient is at least 8 minutes.  Practices that routinely operate a mixed economy of booked and open surgeries should report on both criteria.
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## **PE 1.1 Practice guidance**

The contract includes an incentive for practices to provide longer consultations. This has been included as a proxy for many of the things which are crucial parts of general practice, yet cannot easily be measured – eg listening to patients, taking time, involving patients in decisions, explaining treatments etc, in addition to providing high quality care for the many conditions not specifically included in the quality and outcomes framework.

Practices can claim this payment if their normal booking interval is 10 minutes or more. ‘Normal’ means that three quarters or more of their appointments should be 10 minutes or longer. Deciding whether a practice meets this requirement depends on the booking system.

### **Practices with appointment systems**

For practices where three quarters of patients are seen in booked appointments of 10 minutes or more, and surgery sessions are not normally interrupted by ‘extras’, the contract requirement is met. Extras seen at the end of surgeries and patients seen in emergency surgeries should then not amount to more than a quarter of patients seen.

If extras are routinely seen during surgeries, this will reduce the effective length of time for consultation. For example, if a surgery session has 12 consultations booked at 10 minute intervals, but 6 extras are routinely added in, then the average time for patients will be  $120/18 = 6.7$  minutes, and these slots would not meet the 10 minute requirement. Practices will generally find it easier to decide whether they meet the ‘three quarters’ requirement if extras are seen at the end of routine surgeries, rather than fitted in during them.

Some practices use booking systems which contain a mixture of slots booked at different lengths within a single surgery. In these practices, the overall number of slots which are 10 minutes or more in length should be three quarters of the total.

### **Practices without appointment systems or with mixed systems**

Some practices do not run an appointment system. In this case, or where some surgeries are regularly ‘open’, practices should measure the actual time of consultations in two sample weeks during each year. It is not necessary to do this if fewer than a quarter of patients are seen in open surgeries and the rest of the surgeries are booked at intervals of 10 minutes or more, as the ‘three quarters’ requirement will already be met.

For practices using computerised clinical systems, the length of consultations can be recorded automatically from the computer, providing the doctors know that it is being used for this purpose during the week. Where actual consultation length is measured, the average time with patients should be at least 7.25 minutes. This assumes that the face-to-face time has been 8 minutes in three quarters of consultations (equivalent to the face-to-face time in a 10 minute booked slot), and 5 minutes in the remainder.

## **Unusual systems**

Practices organise consulting in a wide variety of different ways. This Guidance covers the majority of systems. However, if the practice believes that the spirit of the indicator is met but that the evidence it can provide is different, it should have discussions with the PCO at an early stage.

### **PE 1.2 Written evidence**

If submitting on length of consultation, a survey carried out on two separate weeks of consultation length or a computer printout which details the average consultation length should be available. (Grade A)

### **PE 1.3 Assessment visit**

If the practice operate an appointment system, inspection of the appointments book (whether paper or computerised) should be carried out, looking at a sample of days over the preceding year.

If the practice has submitted a survey of consultation length, this should be reviewed.

### **PE 1.4 Assessors' guidance**

The assessors may need to look at a number of sample days to confirm that 75% of consultations have been booked at least at 10 minute intervals.

If a manual survey of average consultation time has been submitted the assessors should question the doctors and reception staff on how and when this was carried out.

<b>PE 2</b>	<b>Patient Surveys (1)</b>
The practice will have undertaken an approved patient survey each year	

### **PE 2.1 Practice guidance**

A practice will meet the contract requirement if it has carried out a survey of patient views in the previous year, using one of two currently approved instruments (GPAQ – the General Practice Assessment Questionnaire, and IPQ – the Improving Practice Questionnaire). Both these instruments have been widely used in the NHS and are currently being modified from their originals in order to meet the requirement of the GP contract. It is likely that other instruments will be added to the approved list following submission to and approval by the National Panel.

GPAQ is a shortened version of GPAS which has been developed for the new contract. GPAQ is available with full instructions at [www.gpas.co.uk](http://www.gpas.co.uk).

IPQ is available at <http://latis.ex.ac.uk/cfep/ipq.htm>

Practices have a choice of how to administer their survey. IPQ and GPAQ can both be administered by giving them to patients attending the surgery, and filled in after consultations with the GP. In addition, GPAQ is available in a version designed to be administered by post. In some cases, if practices consent, a PCO may take responsibility for carrying out a postal survey of all practices in its area.

One advantage of administering questionnaires in the surgery is that they can relate to an individual GP, who will then also be able to use the results in his or her revalidation folder. Surveys carried out by post do not generally relate to a named doctor, except in single-handed practices.

The aim should be to have questionnaires returned by at least 50 patients for each doctor. Only doctors who are permanently in the practice need be included. However, non-principals may benefit from inclusion in order to provide evidence for their revalidation folder. If surveys are carried out in the surgery, these should be conducted on consecutive patients. If carried out by post, adult patients should be randomly sampled, and sufficient questionnaires should be sent out to get 50 questionnaires back.

### **PE 2.2 Written evidence**

Practices should provide evidence that the survey has been undertaken including the date and methodology.

### **PE 3 Patient Surveys (2)**

The practice will have undertaken a patient survey each year, have reflected on the results and have proposed changes if appropriate

### **PE 3.1 Practice guidance**

The practice will undertake one of the surveys detailed in PE 2.

The practice should examine the results of the survey and consider whether there are areas where changes could be made to improve the services and quality of care for patients. This could take the form of a practice meeting involving members of the team.

The practice at level 2 need not provide the results of the survey but should provide an overview of its analysis of the survey and any subsequent proposals for change. Some proposals for change may have resource consequences which need to be discussed with the PCO. This could take the form of a report from a team meeting.

### **PE 3.2 Written evidence**

A report from the practice should be available.

### **PE 4 Patient Surveys (3)**

The practice will have undertaken a patient survey each year and discussed the results as a team and with either a patient group or Non-Executive Director of the PCO. Appropriate changes will have been proposed with some evidence that the changes have been enacted
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#### **PE 4.1 Practice guidance**

Practices should have undertaken a recommended patient survey and have discussed it as a team. (See PE 2 and PE 3.)

Subsequently the team should share its results with a Non-Executive Director of the PCO or with a patient group at a practice meeting. If the practice has a patient participation group then this group may be utilised.

If no patient group exists, one could be convened using one or more of the following methods:

- an advertisement placed in the waiting room at least two weeks before the meeting
- a random sample of patients who are written to and invited by the practice at least three weeks in advance of the meeting
- an advertisement in the practice newsletter if the practice has one
- a leaflet handed out by reception staff or a notice on the side of prescriptions.

Practices may wish to convene a focus group with particular service needs, eg mothers with young children, the elderly etc, with which to share the results of the survey.

#### **PE 4.2 Written evidence**

Practices should submit a report of the meeting which should be agreed with the Non-Executive Director or copied to patients who have attended the meeting. The report should propose changes as appropriate. In subsequent years, evidence that some change has been achieved should be provided by a report or by demonstrating a positive change in the patient survey.

## Section 5: Additional Services

For practices providing additional services the following organisational markers will apply.

<b>Additional</b>	<b>Cervical Screening (CS)</b>
<b>CS 1</b> <b>11 points</b>	The percentage of patients aged from 25 to 64 (in Scotland from 21 to 60) whose notes record that a cervical smear has been performed in the last five years Standard 25 – 80%
<b>CS 2</b> <b>3 points</b>	The practice has a system to ensure inadequate/abnormal smears are followed up
<b>CS 3</b> <b>2 points</b>	The practice has a policy on how to identify and follow up cervical smear defaulters. Patients may opt for exclusion from the cervical cytology recall register by completing a written statement which is filed in the patient record (exception reporting)
<b>CS 4</b> <b>2 points</b>	Women who have opted for exclusion from the cervical cytology recall register must be offered the opportunity to change their decision at least every 5 years
<b>CS 5</b> <b>2 points</b>	The practice has a system for informing all women of the results of cervical smears
<b>CS 6</b> <b>2 points</b>	The practice has a policy for auditing its cervical screening service, and performs an audit of inadequate cervical smears in relation to individual smear-takers at least every 2 years
<i>Additional</i>	<b>Child Health Surveillance (CHS)</b>
<b>CHS 1</b> <b>6 points</b>	Child development checks are offered at the intervals agreed in local or national guidelines and problems are followed up
<i>Additional</i>	<b>Maternity Services (MAT)</b>
<b>MAT 1</b> <b>6 points</b>	Ante-natal care and screening are offered according to current local guidelines
<i>Additional</i>	<b>Contraceptive Services (CON)</b>
<b>CON 1</b> <b>1 point</b>	The team has a written policy for responding to requests for emergency contraception
<b>CON 2</b> <b>1 point</b>	The team has a policy for providing pre-conceptual advice

## **Additional - Cervical Screening (CS)**

### **CS Indicator 1**

**The percentage of patients aged from 25 to 64 (in Scotland from 21 to 60) whose notes record that a cervical smear has been performed in the last 5 years  
Standard 25 – 80%**

#### **CS 1.1 Practice guidance**

This indicator reflects the previous target payment system for cervical screening and is designed to encourage and incentivise practices to continue to achieve high levels of uptake in cervical screening.

The practice should provide evidence of the number of eligible women aged from 25 to 64 (from 21 to 60 in Scotland) who have had a cervical smear performed in the last 60 months.

This indicator differs from all the other additional service indicators in that a sliding scale will apply between 25 and 80%, in a similar fashion to the clinical indicators.

Exception reporting (as detailed in the clinical section) will apply and specifically includes women who have had hysterectomies involving the complete removal of the cervix.

#### **CS 1.2 Written evidence**

There should be a computer print-out showing the number of eligible women on the practice list, the number exception reported and the number who have had an a cervical smear performed in the last 5 years. (Grade A) In many areas the PCO may provide these data although, other than patients with hysterectomy, they will be unaware of exceptions, for example patients who have been invited on three occasions but failed to attend or those who have opted out of the screening programme. Practices should remove patients from the denominator in the same way as with the clinical indicators.

#### **CS 1.3 Assessment visit**

The print-out should be inspected.

### **CS 1.4 Assessors' guidance**

The assessors should enquire on how patients who are exception-reported are identified and recorded.

#### **CS Indicator 2**

**The practice has a system to ensure inadequate/abnormal smears are followed up**

### **CS 2.1 Practice guidance**

If a good system is not in place this is an area of great risk for general practice. The system can be run outwith the practice but needs to cover inadequate and abnormal smears and the practice team need to be aware how it operates.

### **CS 2.2 Written evidence**

The system should be described. (Grade C)

### **CS 2.3 Assessment visit**

The system for follow up is checked.

### **CS 2.4 Assessors' guidance**

It is important to ascertain where the responsibility for the follow-up of abnormal and inadequate smears lies. This is increasingly becoming a centralised function.

#### **CS Indicator 3**

**The practice has a policy on how to identify and follow up cervical smear defaulters. Patients may opt for exclusion from the cervical cytology recall register by completing a written statement which is filed in the patient record (exception reporting)**

### **CS 3.1 Practice guidance**

The policy may have been drawn up outwith the practice but the members of the team need to have knowledge of the policy.

### **CS 3.2 Written evidence**

There should be a written policy. (Grade A).

### **CS 3.3 Assessment visit**

The policy should be discussed with relevant staff.

### **CS 3.4 Assessors' guidance**

It may be necessary to ask the practice to demonstrate how its policy operates.

<b>CS Indicator 4</b>
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<b>Women who have opted for exclusion from the cervical cytology recall register must be offered the opportunity to change their decision at least every 5 years</b>
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### **CS 4.1 Practice guidance**

Women who wish to opt out should not be permanently excluded from the register. Although they need not be sent a reminder letter on a regular basis, it is important that periodically women who have opted out of cytology are given the opportunity to reconsider their decision. There should be a system in place to offer cervical cytology at least every 5 years to those women who have elected to be excluded from recall for cervical cytology.

### **CS 4.2 Written evidence**

There should be a description of how women who opt out of the cervical cytology recall register are identified and offered cervical cytology every 5 years. (Grade C)

### **CS 4.3 Assessment visit**

The practice should demonstrate how women who opt out are identified and recalled.

#### **CS 4.4 Assessors' guidance**

The system may be run centrally but it is important to identify where the responsibility for the system lies.

#### **CS Indicator 5**

**The practice has a system for informing all women of the results of cervical smears**

#### **CS 5.1 Practice guidance**

It is generally accepted as good practice for all women who have had a cervical smear performed to be actively informed of the result. Responsibility for the system may be outwith the practice.

#### **CS 5.2 Written evidence**

There should be a description of system and example of letters sent to patients (Grade C)

#### **CS 5.3 Assessment visit**

The team should be questioned on how women are informed of the way they will obtain the result of their smear.

#### **CS 5.4 Assessors' guidance**

A letter sent to the patient containing and explaining the result is ideal.

## **CS Indicator 6**

**The practice has a policy for auditing its cervical screening service, and performs an audit of inadequate cervical smears in relation to individual smear-takers at least every 2 years**

### **CS 6.1 Practice guidance**

In this audit the criteria, the results, analysis of results, corrective action, the results of the re-audit and a discussion of them needs to be presented. The standard or level of performance against which the criterion is judged would usually involve looking for smear-takers who are obvious outliers in relation to the reading laboratory's average for inadequate smears.

### **CS 6.2 Written evidence**

An audit of inadequate smears should be recorded. (Grade A)

### **CS 6.3 Assessment visit**

A discussion with smear-takers should take place, dealing with the audit and any educational needs which arose and how these were met.

### **CS 6.4 Assessors' guidance**

All the elements for an audit stated in the practice guidance needs to be present. **Additional - Child Health Surveillance (CHS)**

## **CHS Indicator 1**

**Child development checks are offered at the intervals agreed in local or national guidelines and problems are followed up**

### **CHS 1.1 Practice guidance**

The child health surveillance programme should be based on either local or national guidelines. It is important that the practice has a system to ensure follow-up of any identified problem and that referrals are made as appropriate.

### **CHS 1.2 Written evidence**

There should be a description of the child health surveillance programme and how problems are followed up. (Grade C)

### **CHS 1.3 Assessment visit**

The practice team is asked for details of child health surveillance in the practice and how problems are followed up.

### **CHS 1.4 Assessors' guidance**

The practice should be aware of which guidelines it has adopted. The assessors should be content that there is a process to ensure problems are followed up.

### **Additional - Maternity Services (MAT)**

<b>MAT Indicator 1</b>
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<b>Anti-natal care and screening are offered according to current local guidelines</b>
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### **MAT 1.1 Practice guidance**

Most local areas have produced guidelines, which should be adopted within the practice.

### **MAT 1.2 Written evidence**

There should be written guidelines on ante-natal care and screening. (Grade A)

### **MAT 1.3 Assessment visit**

The assessment should involve a description of ante-natal care, using the illustration of one case.

## **MAT 1.4 Assessors' guidance**

The case should show that the guidance is known and is being used.

## **Additional - Contraceptive Services (CON)**

### **CON Indicator 1**

**The team has a written policy for responding to requests for emergency contraception**

### **CON 1.1 Practice guidance**

The purpose of the policy is to ensure requests for emergency contraception are appropriately handled so that it can be offered within the effective time. Receptionists as well as clinicians will need to be aware of and act on the policy.

### **CON 1.2 Written evidence**

There should be a written policy on responding to requests for emergency contraception. (Grade A)

### **CON 1.3 Assessment visit**

The policy should be discussed.

### **CON 1.4 Assessors' guidance**

The policy must allow emergency contraception to be given within the effective time.

### **CON Indicator 2**

**The team has a policy for providing pre-conceptual advice**

### **CON 2.1 Practice guidance**

The policy should cover such areas as smoking, alcohol, diet, prophylactic folic acid, rubella status, any genetically inherited condition, substance abuse and any pre-existing medical condition.

### **CON 2.2 Written evidence**

There should be a written policy for providing pre-conceptual advice. (Grade A)

### **CON 2.3 Assessment visit**

The policy should be discussed.

### **CON 2.4 Assessors' guidance**

All the elements contained in the practice guidance (2.1) should be present in the policy.

## ANNEX F

### CALCULATION OF ADDITIONAL SERVICES ACHIEVEMENT POINTS

F.1 The additional services indicators do not apply to all of the contractor's registered population. Assessment of achievement is carried out in relation to particular target populations. The relevant target populations are–

- Cervical screening services: females aged 25 to 64 years
- Child health surveillance: children of both sexes aged 0 to 5 years
- Maternity medical services: females aged under 55 years
- Contraceptive services: females aged under 55 years

F.2 For example, to meet the requirements of the child health surveillance indicator, child health development checks will only need to be offered to the practice's registered population of children aged 0 to 5 years.

F.3 For each of the additional services mentioned in paragraph F.1, a Target Population Factor is to be calculated as follows–

- (a) first the number of patients registered with the contractor in the relevant target population at the start of the final quarter (**A**) is to be divided by the contractor's CRP at the start of the final quarter (**B**);
- (b) then the average number of patients registered with all contractors in England in the relevant target population at the start of the final quarter (**C**) is to be divided by the average CRP for England (according to the Exeter Registration System) at the start of the final quarter (**D**); and
- (c) the number produced by the calculation in paragraph (a) is then to be divided by the number produced by the calculation in paragraph (b) to produce the Target Population Factor for the additional service in question.

F.4 The Target Population Factor for the additional service is to be multiplied by £75 and by the Achievement Points obtained in respect of the additional service (**E**) to produce the cash total in respect of the additional service (**F**).

F.5 This calculation could be expressed as–

$$\frac{(A \div B)}{(C \div D)} \times £75 \times E = F$$

F.6 If the contractor has not been under an obligation to provide an additional service for any period during the financial year 2004 to 2005 when the contractor's contract had effect, the adjusted total for that particular additional service to be further adjusted by the fraction produced by dividing–

- (a) the number of days in the financial year during which the contract had effect and the contractor was under an obligation to provide the additional service; by
- (b) the number of days in the financial year during which the contract had effect.

F.7 The resulting cash amounts, in respect of each additional service, are then to be added together for the total amount in respect of the additional services domain.

## ANNEX G

### ADJUSTED PRACTICE DISEASE FACTOR CALCULATIONS

G.1 The calculation involves three steps:

- first, the calculation of the contractor's Raw Practice Disease Prevalences. There will be a Raw Practice Disease Prevalence in respect of each disease area for which the contractor is seeking to obtain Achievement Points;
- secondly, making an adjustment to give an Adjusted Practice Disease Factor (APDF);
- thirdly, applying the factor to the pounds per point figure for each disease area.

G.2 These steps are explained below.

G.3 The Raw Practice Disease Prevalence is calculated by dividing the number of patients on the relevant disease register by the contractor's CRP for the last quarter.

G.4 The Adjusted Practice Disease Factor is calculated by:

- (a) calculating the national range of Raw Practice Disease Prevalences in England and applying a 5% cut-off at the bottom of the range. Contractors below this will be treated as having the same prevalence as the cut-off point;
- (b) once the cut-off has been applied, making a square root transformation to all the contractor prevalence figures. This means that the prevalence distribution will be compressed to a narrower range. It will prevent financial destabilisation of those with the lowest prevalence;
- (c) after the transformation, rebasing the contractor figures around the new national English mean to give the Adjusted Practice Disease Factor (APDF). For example, an ADPF of 1.2 indicates a 20% greater prevalence than the mean, in the adjusted distribution. The rebasing ensures that the average contractor (i.e. one with an ADPF of 1.0) receives £75 per point, after adjustment;
- (d) thus, adjusting via the factor the contractor's average pounds per point for each disease, rather than the contractor's points score. For example, a contractor with an APDF of 1.2 for CHD will receive £90 per point scored on the CHD indicators.

G.5 As a result of this calculation, each contractor will have a different 'pounds per point' figure for each disease area, and it will then be possible to use these figures to calculate a cash total in relation to the points scored in each disease area.

G.6 This national prevalence figure and range of practice prevalence will be calculated on an England-only basis.

## ANNEX H

### LIST OF PCT AREAS FOR WHICH ADDITIONAL PAYMENTS ARE PAYABLE UNDER THE GOLDEN HELLO SCHEME

<b>Primary Care Trust (PCT)</b>	<b>PCT Code</b>
Adur, Arun & Worthing PCT (area bounded by the former Adur PCG and Arun PCG only)	5L8
Ashfield PCT	5FA
Ashford PCT	5LL
Ashton, Leigh & Wigan PCT	5HG
Barking & Dagenham PCT	5C2
Barnsley PCT	5JE
Basildon PCT	5GR
Bassetlaw PCT	5ET
Bedford PCT	5GD
Bexhill & Rother PCT	5FH
Bexley Care Trust	TAK
Birkenhead & Wallasey PCT (area bounded by the former Birkenhead PCG only)	5H2
Blackburn with Darwen PCT	5CC
Blackpool PCT	5HP
Bolton PCT (area bounded by the former Bolton North East PCG and Bolton South East PCG only)	5HQ
Bradford City PCT	5CF
Brent PCT (area bounded by the former Brent Central PCG only)	5K5
Brighton & Hove PCT	5LQ
Bristol North PCT (area bounded by the former Bristol East PCG only)	5JF
Bromley PCT (area bounded by the former Beckenham & Penge PCG only)	5A7
Broxtowe & Hucknall PCT	5EV
Burnley, Pendle & Rossendale PCT	5G8
Burntwood, Lichfield & Tamworth PCT	5DQ
Bury PCT (area bounded by the former Bury South PCG only)	5JX
Calderdale PCT	5J6
Camden PCT (area bounded by the former South Camden PCG only)	5K7
Cannock Chase PCT	5MM
Canterbury & Coastal PCT	5LM
Castle Point & Rochford PCT	5JP
Central Cheshire PCT	5H4
Central Cornwall PCT (area bounded by the former Restormel PCG only)	5KT
Central Derby PCT	5AL
Central Liverpool PCT	5HA
Central Manchester PCT	5CL
Chesterfield PCT	5EA
Chorley & South Ribble PCT	5F2
City & Hackney PCT	5C3
Coventry PCT (area bounded by the former Coventry East PCG and Coventry North PCG only)	5MD
Crawley PCT	5MA
Croydon PCT	5K9
Darlington PCT	5J9
Derbyshire Dales & South Derbyshire PCT	5H7

Derwentside PCT	5KA
Doncaster Central PCT	5CK
Doncaster East PCT	5EK
Doncaster West PCT	5EL
Dudley Beacon & Castle PCT	5HV
Dudley South PCT	5HT
Durham & Chester-le-Street PCT	5KC
Durham Dales PCT	5J8
Ealing PCT (area bounded by the former Southall and West Ealing PCG only)	5HX
Easington PCT	5KD
East Cambridge & Fenland PCT (area bounded by the former Fenland PCT only)	5JK
East Devon PCT	5FT
East Kent Coastal PCT	5LN
East Lincolnshire PCT	5H9
East Staffordshire PCT	5ML
East Yorkshire PCT	5E3
Eastbourne Downs PCT	5LR
Eastern Birmingham PCT	5MY
Eastern Hull PCT	5E5
Eastern Leicester PCT	5EY
Eastern Wakefield PCT	5E7
Enfield PCT (area bounded by the former Edmonton PCG only)	5C1
Erewash PCT	5ER
Exeter PCT	5FR
Fareham & Gosport PCT (area bounded by the former Gosport PCG only)	5LX
Fylde PCT	5HE
Gateshead PCT	5KF
Gedling PCT	5EC
Great Yarmouth PCT	5GT
Greater Derby PCT	5EX
Greenwich PCT	5A8
Halton PCT	5J1
Hammersmith and Fulham PCT (area bounded by the former Fulham PCG only)	5H1
Haringey Teaching PCT (area bounded by the former Haringey PCG only)	5C9
Hartlepool PCT	5D9
Hastings & St Leonards PCT	5FJ
Havering PCT	5A4
Heart of Birmingham Teaching PCT	5MX
Heywood & Middleton PCT	5F4
Hounslow PCT (area bounded by the former Hounslow PCG only)	5HY
Huddersfield Central PCT	5LJ
Hyndburn & Ribble Valley PCT (area bounded by the former Hyndburn PCG only)	5G7
Ipswich PCT	5JQ
Islington PCT (area bounded by the former North Islington PCG only)	5K8
Kennet & North Wiltshire PCT (area bounded by the former Ridgeway Downs PCG only)	5K4
Kensington & Chelsea PCT	5LA
Knowsley PCT	5J4
Lambeth PCT	5LD
Langbaugh PCT	5KN
Leeds West PCT	5HH
Leicester City West PCT	5EJ
Lewisham PCT	5LF
Luton PCT	5GC

Mansfield District PCT	5AM
Medway PCT (area bounded by the former Rainham & Gillingham PCG and Rochester & Strood PCG only)	5L3
Melton,Rutland & Harborough PCT	5EH
Middlesbrough PCT	5KM
Morecambe Bay PCT (area bounded by the former Lancaster PCG and Barrow PCG only)	5DD
Newark & Sherwood PCT	5AP
Newcastle PCT	5D7
Newcastle under Lyme PCT	5HW
Newham PCT	5C5
North & East Cornwall PCT (area bounded by the former North Cornwall PCG only)	5KR
North Birmingham PCT (area bounded by the former Perrybarr PCG only)	5MW
North Dorset PCT	5CD
North East Lincolnshire PCT	5AN
North Eastern Derbyshire PCT	5EG
North Kirklees PCT	5J7
North Lincolnshire PCT	5EF
North Liverpool PCT (area bounded by the former Merseylive PCG only)	5G9
North Manchester PCT	5CR
North Norfolk PCT	5JM
North Peterborough PCT	5AF
North Sheffield PCT	5EE
North Somerset PCT (area bounded by the former Weston PCG only)	5M8
North Stoke PCT	5ME
North Surrey PCT (area bounded by the former Surrey Thames PCG only)	5L6
North Tees PCT	5E1
North Tyneside PCT	5D8
North Warwickshire PCT (area bounded by the former Nuneaton & Bedworth PCG only)	5MP
Northamptonshire Heartlands PCT (area bounded by the former Corby PCG, Nene Valley PCG and Kettering PCG only)	5LV
Northumberland Care Trust (area bounded by the former Blyth Valley, Northumberland PCG and Central (Wansbeck & Morpeth) PCG only)	TAC
Norwich PCT	5A2
Nottingham City PCT	5EM
Oldbury and Smethwick PCT	5MG
Oldham PCT	5J5
Poole PCT (area bounded by the former Poole Bay PCT only)	5KV
Preston PCT	5HD
Redbridge PCT	5NA
Richmond & Twickenham PCT (area bounded by the former Teddington, Twickenham & Hamptons PCT only)	5M6
Rochdale PCT	5JY
Rotherham PCT	5H8
Rowley, Regis & Tipton PCT	5MH
Salford PCT	5F5
Sedgefield PCT	5KE
Shepway PCT	5LP
Shropshire County PCT (area bounded by the former Shrewsbury & Atcham PCG only)	5M2
Slough PCT	5DM
Solihull PCT (area bounded by the former North Solihull PCG only)	5D1
South Birmingham PCT (area bounded by the former Hall Green PCG only)	5M1
South East Sheffield PCT	5EQ
South Leeds PCT	5HL

South Liverpool PCT	5HC
South Manchester PCT	5AA
South Peterborough PCT	5AG
South Sefton PCT	5M5
South Stoke PCT	5MF
South Tyneside PCT	5KG
South Warwickshire PCT (area bounded by the former Warwick & District PCG only)	5MQ
South Worcestershire PCT (area bounded by the former Worcester City PCG only)	5MT
Southend On Sea PCT	5AK
Southern Norfolk PCT (area bounded by the former Breckland PCG only)	5G1
Southport & Formby PCT	5F9
Southwark PCT	5LE
St Helens PCT	5J3
Staffordshire Moorlands PCT	5HR
Stockport PCT (area bounded by the former Stockport North PCG only)	5F7
Suffolk West PCT (area bounded by the former Bury St Edmunds PCG only)	5JW
Sunderland Teaching PCT	5KL
Sutton & Merton PCT (area bounded by the former East Merton & Furzedown PCG and Sutton PCG only)	5M7
Swale PCT	5L4
Tameside & Glossop PCT	5LH
Teignbridge PCT	5FY
Telford & Wrekin PCT	5MK
Tendring PCT	5AH
Thurrock PCT	5GQ
Torbay PCT	5CW
Tower Hamlets PCT	5C4
Trafford North PCT	5F6
Trafford South PCT	5CX
Walsall PCT (area bounded by the former Walsall South PCG, Walsall North PCG and Walsall West PCG only)	5M3
Waltham Forest PCT (area bounded by the former Walthamstow, Leyton & Leytonstone PCG only)	5NC
Wandsworth PCT (area bounded by the former Putney and Roehampton PCG and Battersea PCG only)	5LG
Warrington PCT	5J2
Waveney PCT	5JV
Wednesbury and West Bromwich PCT	5MJ
West Hull PCT	5E6
West Lancashire PCT	5F3
West Lincolnshire PCT	5D2
West of Cornwall PCT	5FM
Western Sussex PCT	5L9
Westminster PCT	5LC
Witham, Braintree & Halstead Care Trust	TAG
Wolverhampton City PCT	5MV
Wyre PCT	5DR

# ANNEX I DISPENSING PAYMENTS

## PART 1 DISCOUNT SCALE

<i>Total basic price per month - £ bandwidth</i>	<i>New discount rate (%)</i>
1 –2000	3.17
2001 – 4000	5.93
4001 – 6000	7.21
6001 – 8000	8.06
8001 – 10 000	8.68
10 001 – 12 0000	9.19
12 001 – 14 000	9.60
14 001 – 16 000	9.97
16 001 – 18 000	10.29
18 001 – 20 000	10.57
20 001 – 22 000	10.82
22 001 – 24 000	11.03
24 001 and above	11.18

## PART 2 DISPENSING FEESCALE FOR CONTRACTORS THAT ARE AUTHORISED OR REQUIRED TO PROVIDE DISPENSING SERVICES

<i>Total prescriptions in bands</i>	<i>Prices per prescription in pence</i>
Up to 400	124.9
401 – 500	123.6
501 – 600	120.9
601 – 700	116.3
701 – 800	112.8
801 – 900	110.1
900 – 1250	107.8
1251 – 1750	107.3
1751 – 2000	106.5
2001 – 2500	104.3
2501 – 3000	103.1
3001 – 3500	101.7
3501 – 4000	99.4
4001 and over	98.2

## PART 3

**DISPENSING FEESCALE FOR CONTRACTORS THAT ARE NOT  
AUTHORISED OR REQUIRED TO PROVIDE DISPENSING SERVICES**

<i>Total prescriptions in bands</i>	<i>Prices per prescription in pence</i>
Up to 400	120.5
401 – 500	119.3
501 – 600	116.8
601 – 700	112.4
701 – 800	109.0
801 – 900	106.4
900 – 1250	104.2
1251 – 1750	103.7
1751 – 2000	103.0
2001 – 2500	100.9
2501 – 3000	99.7
3001 – 3500	98.3
3501 – 4000	96.2
4001 and over	95.1

**PART 4  
OXYGEN AND OXYGEN EQUIPMENT**

***Rental payments in respect of oxygen equipment***

I.1 If a contractor is authorised or required to provide dispensing services to specific patients, the PCT must pay to it under its GMS contract a monthly amount, which is to fall due on the last day of the month, in respect of each oxygen set or stand that the contractor is authorised to hold by the PCT. The amounts payable are as follows–

- (a) for a lightweight (single unit) set as specified in the Drug Tariff, including one plastic mask: £1.94 per month; and
- (b) for a stand for use with a 1360 litre oxygen cylinder: 43p per month.

I.2 Any contractor wishing to be authorised to hold oxygen sets or stands, or increase the number of oxygen sets or stands it is authorised to hold, should make a written application to its PCT stating the number of oxygen sets or stands, or the number of additional oxygen sets or stands, it wishes to hold. Before authorising any increase in the number of oxygen sets or stands held by a contractor, the PCT must satisfy itself, after consultation with the LMC (if there is one), that the current holding of oxygen sets or stands by the contractor is insufficient to provide an adequate oxygen therapy service in the light of the current and foreseeable demands upon the contractor.

I.3 If the PCT is satisfied that a new authorisation, or an increase to the number of oxygen sets or stands held under an existing authorisation, is justified, it must

immediately notify the PPA at Bridge House, 152 Pilgrim Street, Newcastle-upon-Tyne, NE1 6SN, informing it of the number of sets or stands (or the new number of sets or stands) that it has authorised the contractor to hold.

***Conditions attached to rental payment in respect of oxygen equipment***

I.4 The monthly payments under paragraph I.1 are only payable if the contractor notifies both the PCT and the PPA each month, as regards the sets and cylinders that it is authorised to hold of–

- (a) which sets and cylinders, in the month to which the payment relates, have been out on loan; and
- (b) the date on which, if a set or cylinder has been out on loan, the loan commenced.

I.5 If the contractor breaches the condition set out in paragraph I.4, the PCT may, in appropriate circumstances, withhold payment of any or any part of a payment that is otherwise payable under paragraph I.1.

***Payments in respect of prescriptions for oxygen and masks***

I.6 If a contractor has been granted the right to secure the provision of dispensing services, and a medical practitioner who has been employed or engaged by that contractor supplies oxygen or a mask for oxygen as part of those services, the PCT must pay to the contractor under its GMS contract–

- (a) for the supply of–
  - (i) a mask, the basic price for that mask, as specified in the Drug Tariff, Part X, item 4b(ii), and
  - (ii) Oxygen BP, the basic price for that oxygen, as specified in the Drug Tariff, Part X, item 4b(ii); and
- (b) exceptional expenses, as provided for in Part II, clause 12, of the Drug Tariff.

I.7 However, payment in respect of prescriptions for oxygen, or masks for oxygen, shall be subject to any deduction required to be made under the National Health Service (Charges for Drugs and Appliances) Regulations in respect of charges required to be made and recovered by a dispensing practitioner.

***Condition attached to payments in respect of prescriptions for oxygen and masks***

I.8 The payments listed in paragraph I.6 are only payable if the contractor has noted, counted and sent all the prescriptions in respect of which it wishes to claim reimbursement to the PPA, Bridge House, 152 Pilgrim Street, Newcastle-upon-Tyne, NE1 6SN, not later than the 5th of the month following the month to which the prescriptions relate.

**Value Added Tax**

I.9 Unless the contractor is registered with Customs and Excise for VAT purposes, the PCT must pay to the contractor under its GMS contract an allowance to cover the VAT payable on the purchase of oxygen, cylinders and masks, if it is being reimbursed in respect of those items pursuant to this Annex. The allowance is to be calculated as a percentage of the basic price, and for these purposes, the rate payable shall be equivalent to the percentage rate of VAT in force on the first day of the quarter in which the items were dispensed.

**Professional fees**

I.10 Where–

- (a) as part of a contractor’s dispensing services, a medical practitioner visits a patient to deliver or collect an oxygen set or cylinders (and makes that visit solely for that purpose); and
- (b) the contractor submits a claim in respect of that visit within a reasonable period of time after that visit was undertaken,

the PCT must pay to the contractor under its GMS contract a professional fee in respect of the visit, calculated – as set out in the table below – on the basis of the length of the return journey to make that visit–

		<i>Nature of journey</i>	<i>0-3 miles</i> £	<i>3-5 miles</i> £	<i>5-10 miles</i> £	<i>Over 10 miles</i> £
(a)		<i>Delivery of set and cylinders or of replacement set, or return visit to check and remedy set (but not cylinder) malfunction</i>				
	(i)	except on public holidays: between 8am and 7pm, Mondays to Fridays, and 8am to 1pm on Saturdays	17.84	24.55	26.41	33.95
	(ii)	except on public holidays: between 7pm and 11pm, Mondays to Fridays, and 1pm to 11pm on Saturdays	28.64	35.35	37.21	44.75
	(iii)	between 11pm and 8am, Mondays to Saturdays, and throughout Sundays and public holidays	31.04	37.75	39.61	47.15
(b)		<i>Delivery of cylinders (when not in conjunction with a set)</i>  <i>Delivery of masks (when not in conjunction with set or cylinders)</i>  <i>Delivery of replacement cylinder</i>				

		<i>when original cylinder found to be faulty</i>				
		<i>Ineffective first delivery journey of set and/or cylinder</i>				
	(i)	except on public holidays: between 8am and 7pm, Mondays to Fridays, and 8am to 1pm on Saturdays	16.06	22.81	24.67	32.24
	(ii)	except on public holidays: between 7pm and 11pm, Mondays to Fridays, and 1pm to 11pm on Saturdays	26.86	33.61	35.47	43.04
	(iii)	between 11pm and 8am, Mondays to Saturdays, and throughout Sundays and public holidays	29.26	36.01	37.87	45.44
	(c)	<i>Collection of sets and cylinders at the end of treatment</i>				
		at any time	16.06	22.81	24.67	32.24

I.11 Where–

- (a) as part of a contractor’s dispensing services, a medical practitioner visits a patient –
  - (i) to deliver or collect an oxygen set or cylinders to a patient, but
  - (ii) the visit is also made for another purpose; or
- (b) in connection with a contractor’s dispensing service, someone (e.g. a relative or friend) visits the contractor’s practice premises to collect or return an oxygen set, cylinders or masks,

and the contractor submits a claim in respect of that visit within a reasonable period of time after that visit was undertaken, the PCT must pay to the contractor under its GMS contract a professional fee in respect of the visit, calculated – as set out in the table below – on the basis of each visit–

		<i>Items delivered/returned</i>	<i>Fee claimed per visit</i> £
(a)		<i>Sets and cylinders or a replacement set</i>	
	(i)	except on public holidays: between 8am and 7pm, Mondays to Fridays, and 8am to 1pm on Saturdays	8.81
	(ii)	except on public holidays: between 7pm and 11pm, Mondays to Fridays, and 1pm to 11pm on Saturdays	24.10
	(iii)	between 11pm and 8am, Mondays to Saturdays, and throughout Sundays and public holidays	27.10
(b)		<i>Cylinders only (when not in conjunction with a set)</i>	
	(i)	except on public holidays: between 8am and 7pm, Mondays to Fridays, and 8am to 1pm on Saturdays	7.91

	(ii)	except on public holidays: between 7pm and 11pm, Mondays to Fridays, and 1pm to 11pm on Saturdays	23.21
	(iii)	between 11pm and 8am, Mondays to Saturdays, and throughout Sundays and public holidays	26.21
(c)		<i>Masks only (when not in conjunctions with a set or cylinders)</i>	
	(i)	except on public holidays: between 8am and 7pm, Mondays to Fridays, and 8am to 1pm on Saturdays	0.31
	(ii)	except on public holidays: between 7pm and 11pm, Mondays to Fridays, and 1pm to 11pm on Saturdays	15.61
	(iii)	between 11pm and 8am, Mondays to Saturdays, and throughout Sundays and public holidays	16.82

I.12 However, as regards the delivery, collection or return of cylinders, expenses are only payable–

- (a) in respect of the actual number of visits; or
- (b) on the basis of one fee in respect of every three cylinders, or the balance of an order,

whichever is the lower of sub-paragraph (a) or (b).