Section 1: Introduction

The Quality and Outcomes Framework (QOF) rewards contractors for the provision of quality care and helps to standardise improvements in the delivery of primary medical services. Contractor participation in QOF is voluntary.

QOF was introduced as part of the new GMS contract in 2004.

From May 2006, evidence was provided by an 'expert panel', coordinated by a consortium of academic bodies, including the Universities of Birmingham and Manchester, which informed negotiations between NHS Employers, on behalf of the four UK health departments and the General Practitioners Committee (GPC) of the British Medical Association (BMA) on what changes should be made to the QOF each year.

The National Institute for Health and Clinical Excellence (NICE) became responsible for managing an independent and transparent approach to developing the QOF clinical and health improvement indicators from April 2009.

Changes to QOF are agreed as part of wider changes to the General Medical Services (GMS) Contract. Since 2013 changes to the GMS Contract for Wales have been negotiated annually by Welsh Government and the General Practitioners Committee Wales (GPCW) of the British Medical Association.

This document includes a copy of the summary of indicators for the 2017/18 QOF as set out in Annex D of the General Medical Services (GMS) Statement of Financial Entitlements Directions (SFE) and provides additional guidance on the indicators in Wales. It replaces all guidance issued in previous years. Annex D to the SFE forms part of the GMS contract for 2017/18.

NICE operates an online facility which allows stakeholders to comment on current QOF indicators. Comments inform the review of existing QOF indicators against set criteria which include:

- evidence of unintended consequences
- significant changes to the evidence base
- changes in current practice.

These comments are fed in to a rolling programme of reviews and considered by the QOF Advisory Committee. The recommendations of the Committee will then be considered during negotiations between Welsh Government and the GPCW on potential changes to QOF. The online facility is available on the NICE website[1].

The focus for new indicators is provided by NICE Quality Standards. Interested individuals/organisations are encouraged to register with NICE as a stakeholder in the development of individual quality standards. Once registered, stakeholders are

[1] NICE website. QOF. www.nice.org.uk/aboutnice/qof/qof.jsp

able to comment on the content of quality standards during their development. The comments facility and full details of quality standards in development are available on the NICE website.[2]

Principles

The following principles relating to the QOF have been agreed by the negotiating parties:

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 is 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 e.g. data required for audit purposes should be data routinely collected for patient care and obtained from existing practice clinical systems.

2017/18 GMS Contract Agreement

The agreed changes to the GMS Contract for 2017/18 reflects the intention to reduce unnecessary bureaucracy and place greater reliance on cluster based peer review of clinical indicators deemed to be embedded in clinical practice. As part of the agreed changes to QOF, five indicators have been removed [CVD PP 001W ; BP 001W; DEP 003W; HF 005W; COPD 008W] and the 40 points associated with these indicators have been transferred to the cluster network domain.

The clinical domain for 2017/18 comprises two areas: active clinical QOF indicators and inactive clinical QOF indicators. Active clinical QOF will operate in the usual way with contactors achievement being calculated at the year end.

Inactive clinical QOF are those indicators which contractors performance will not be measured for payment. Instead payment will be made to contractors at the same points level as 2016/17 achievement. As outlined in the cluster network domain, contractors will peer review inactive clinical QOF in order to gain assurance on standards.

General information on indicators

[2] NICE website. Quality standards. www.nice.org.uk/aboutnice/qof/qof.jsp

Indicators across all domains were renumbered from April 2013. Since April 2013 indicators have been prefixed by an abbreviation of the category to which they belong, for example coronary heart disease (CHD) indicator number one, became CHD001. The addition of zeros indicated the change from previous years numbering. From 2014/15 a consistent approach to numbering was adopted by Welsh Government, Scottish Government and the Northern Ireland Executive, the new approach means that a couple of indicators that were numbered 100W in 2013/14 were renumbered for 2014/15.

Active QOF indicators

For the purposes of calculating achievement payments against active QOF indicators contractor achievement is measured:

- on the last day of the relevant financial year (31 March); or
- in the case where the contract terminates mid-year, on the last day on which the contract subsists. For example, for payments relating to the financial year 1 April 2017 to 31 March 2018, unless the contract terminates mid-year, achievement is measured on 31 March 2018. If the GMS contract ends on 30 June 2017, achievement is measured on 30 June 2017.

Indicators generally set out the target, intervention or measurement to be recorded within a specified time period to establish eligibility for achievement payments. Unless otherwise stated, time periods referred to mean the period which ends on the last day of the financial year to which the achievement relates. For example:

Indicator CAN003W - *"The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the contractor receiving confirmation of the diagnosis, or where clinically appropriate within 3 months",* the phrase "within the preceding 15 months" means the period of 15 months which ends on 31 March in the financial year to which the achievement payments relate; This patient review can be undertaken via a telephone consultation but with an offer of a face to face appointment.

- Indicator HYP006 – *"The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less"*, the phrase "in the preceding 12 months" means the period of 12 months which ends on 31 March in the financial year to which the achievement payments relate.
- Indicator CS002 – *"The percentage of women (aged 25 or over and under the age of 65) whose notes record that a cervical screening test has been performed in the preceding 5 years"* the phrase *"in the preceding 5 years"* means the period of five years which ends on 31 March in the financial year to which the achievement payments relate.

For clarity, the following points apply to any indicators in which age or date ranges are referenced:

- Where an indicator refers to the financial year, this means the period of 12 months from 1 April to 31 March.

- Patients are considered to be 'currently treated' with a specified medicine if they have had a prescription for that medicine within the preceding six months ending on the last day of the financial year to which the achievement payments relate.

In the case of a contract that has come to an end before 31 March in any relevant financial year , the reference to periods of time are still calculated on the basis that the period ends on 31 March in the financial year to which the achievement payment relates. Paragraph 4A.5 of the SFE sets out the rules that apply to measuring achievement for contracts that end before the end of the financial year.

Inactive QOF Indicators

Inactive clinical QOF are those indicators which contractors performance will not be measured for payment. Instead payment will be made to contractors at the same points level as 2016/17 achievement. As outlined in the cluster network domain, contractors will peer review elements of inactive clinical QOF in order to gain assurance on standards. This “light touch” review will be based on data available through the current system and will focus on specific indicators.

In the case of a contract that has come to an end before 31 March in any relevant financial year , the reference to periods of time are still calculated on the basis that the period ends on 31 March in the financial year to which the achievement payment relates. Annex D of the SFE sets out the rules that apply to measuring achievement for contracts that end before the end of the financial year.

Disease registers

An important feature of the QOF is the establishment of disease registers. These are lists of patients registered with the contractor who have been diagnosed with the disease or risk factor described in the register indicator. While it is recognised that these may not be completely accurate, it is the responsibility of the contractor to demonstrate that it has systems in place to maintain a high quality register. Verification may involve asking how the register is constructed and maintained. The LHB may compare the reported prevalence with the expected prevalence and ask contractors to explain any reasons for variations.

For some indicators, there is no disease register, but instead there is a target population group. For example, for cervical screening the target population group is women who are aged 25 years or over and under the age of 65. Indicators in the clinical domain are arranged in terms of clinical areas. Most of these areas either relate to a register or to a target population group.

Some areas in the clinical domain do not have a register indicator, or there may be more than one register to calculate the Adjusted Practice Disease Factor (APDF) for different indicators within the area. For all relevant disease areas, the registered

population used to calculate the APDF are set out in the summary of indicators section.

Indicators in the GP Cluster Network Development Domain have neither a disease register nor a target population. These are indicators which require a particular activity to be carried out and where the points available are awarded in full if it is carried out or not at all if it is not carried out.

Verification

For indicators where achievement is not extracted automatically from GP clinical systems the guidance outlines the evidence which the LHB may require the contractor to produce for verification purposes. The evidence would not need to be submitted unless requested by LHB.

The SFE sets out the reporting requirements for contractors and the rules for the calculation of QOF payments. It states (see section 5.17 (c) - (e) of the directions):

(c) "contractors utilising computer systems approved by the LHB must make available to the LHB aggregated monthly returns relating to the contractors achievement of the standards contained in the indicators in the QOF, and in the standard form provided for by such systems;

(d) contractors not utilising computer systems approved by the LHB must make available to the LHB similar monthly returns, in such form as the LHB may reasonably request that a contractor fill in manually a printout of the standard spreadsheet in the form specified by the LHB); and

(e) all information supplied pursuant to or in accordance with this paragraph must be accurate."

The SFE states (section 6.4) that in order for a contractor to claim payment for achievement *"a contractor must make a return in respect of the information required of it by the LHB in order for the LHB to calculate its achievement payment"*.

Data from GP clinical systems will be sent to CM Web for QOF achievement purposes.

The SFE states (paragraph D16): *"The contractor must ensure that it is able to provide any information that the LHB 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 LHB on request. In verifying that an indicator has been achieved and information correctly recorded."*

Where 'reporting and verification' is included it provides additional information to support practices in meeting the criteria for the indicator.

The terms 'notes' and 'patient record' are used throughout this document to indicate either electronic or paper patient records.

For inactive QOF indicators , information will still be collected from GP clinical systems and sent to CM Web for the purposes of assurance of standards. Health boards will not be verifying achievement as payment will be made to contractors at the same points level as 2016/17 achievement.

Contractors will engage in peer review through the cluster networks to gain assurance on standards on elements of the inactive QOF. Indicators DM 002, DM 003, DM 007, DM 012, DM 014, COPD 002; COPD 003; and COPD 005 will be subject to peer review during 2017/18 to provide assurance on standards. The peer review will be undertaken through cluster networks which is an element of CND 011W Cluster Network Domain. Other indicators designated as “inactive” may also be considered for peer review if specific cause for concern is identified.

Business rules

Since April 2015 different contractual arrangements for QOF have applied in each country of the UK, requiring different Business Rules to support QOF in Wales. The development of Business Rules to support QOF is now undertaken by NHS Wales Informatics Service (NWIS) on behalf of Welsh Government. The clinical system suppliers to practices in Wales work to the Business Rules developed to support the QOF in Wales.

The Dataset and Business Rules that support the reporting requirements of the QOF are based entirely on Read codes (version 2 and Clinical Terms Version 3) and associated dates. Read codes are an NHS standard and are shortly due to be replace by SNOMED clinical terms. Contractors using proprietary coding systems and/or local/practice specific codes will need to be aware that these codes will not be recognised within QOF reporting. Contractors utilising such systems may need to develop strategies to ensure that they are using appropriate codes that meet NHS standards in advance of producing their achievement report.

The Dataset and Business Rules and will be made available from the GMS Contract Wales website during 2017/18 [3].

Exception reporting

Exception reporting applies to those indicators in any domain of the QOF where the achievement is determined by the percentage of patients receiving the specified level of care.

Some indicators refer to a sub-set of patients on the relevant disease register, or in the target population group. Patients who are on the disease register or in the target group for the clinical area concerned, but not included in an indicator denominator for definitional reasons are called “exclusions”.

[3] GMS Contract Wales website. www.wales.nhs.uk/GMS

"Exceptions" relate to registered patients who are on the relevant disease register or in the target population group and would ordinarily be included in the indicator denominator, but who are excepted by the contractor on the basis of one or more of the exception criteria. Patients are removed from the denominator and numerator for an indicator if they have been both excepted and they have not received the care specified in the indicator wording. If the patient has been excepted but subsequently the care has been carried out within the relevant time period the patient will be included in both the denominator and the numerator (e.g. achievement will always override an exception).

Exception reporting criteria

Patients may be excepted if they meet the following criteria 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 financial year to which the achievement payments relate (except in the case of indicator CS002, where the patient should have been invited on at least three occasions during the period of time specified in the indicator during which achievement is to be measured (e.g. the preceding five years ending on 31 March in the financial year to which achievement payments relate).

B. Patients for whom it is not appropriate to review the chronic disease parameters due to particular circumstances, for example, a patient who has a terminal illness or is extremely frail.

C. Patients newly diagnosed or who have recently registered with the contractor who should have measurements made within three months and delivery of clinical standards within nine months e.g. blood pressure or cholesterol measurements within target levels.

D. Patients who are on maximum tolerated doses of medication whose levels remain sub-optimal.

E. Patients for whom prescribing a medication is not clinically appropriate e.g. those who have an allergy, contra-indication 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 patient record following a discussion with the patient.

H. Where the patient has a supervening condition which makes treatment of their condition inappropriate e.g. cholesterol reduction where the patient has liver disease.

I. Where an investigative service or secondary care service is unavailable.

In the case of exception reporting on criteria A and B these patients are removed from the denominator for all indicators in that disease area where the care had not been delivered. For example, a contractor with 100 patients on the diabetes mellitus (DM) disease register, of 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. However, all 100 patients with DM would be included in the calculation of APDF (practice prevalence). This would apply to all relevant indicators in the DM set.

Contractors should report the number of exceptions for each indicator set and individual indicator. Contractors will not be expected to report why individual patients were exception reported. However, contractors may be called on to explain why they have 'excepted' patients from an indicator and this can be identifiable in the patient record.

Additional guidance on exception reporting can be found in section eight.

Section 2: Summary of all indicators

Section 2.1 Clinical Domain Active QOF

Atrial fibrillation (AF)

Indicator	Points	Achievement thresholds
Records		
AF001. The contractor establishes and maintains a register of patients with atrial fibrillation	2	
Ongoing management		
AF006 The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using CHA2DS2-VASc score risk stratification scoring system in the preceding 3 years (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more)	12	50-90%
AF007 In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anticoagulation drug therapy	12	40-70%

Secondary prevention of coronary heart disease (CHD)

Indicator	Points	Achievement thresholds

Records		
CHD001. The contractor establishes and maintains a register of patients with coronary heart disease	2	

Heart failure (HF)

Indicator	Points	Achievement thresholds
Records		
HF001. The contractor establishes and maintains a register of patients with heart failure	2	

Hypertension (HYP)

Indicator	Points	Achievement thresholds
Records		
HYP001. The contractor establishes and maintains a register of patients with established hypertension	2	
Ongoing management		
HYP006. The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	25	45-80%

Stroke and transient ischaemic attack (STIA)

Indicator	Points	Achievement thresholds
Records		
STIA001. The contractor establishes and maintains a register of patients with stroke or TIA	2	

Diabetes mellitus (DM)

Indicator	Points	Achievement thresholds

Records		
DM001. The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed *NICE 2011 menu ID: NM41*	2	

Asthma (AST)

Indicator	Points	Achievement thresholds
Records		
AST001. The contractor establishes and maintains a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the preceding 12 months	2	
Ongoing management		
AST003. The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 15 months that includes an assessment of asthma control using the 3 RCP questions *NICE 2011 menu ID: NM23*	20	45–70%

Chronic obstructive pulmonary disease (COPD)

Indicator	Points	Achievement thresholds
Records		
COPD001. The contractor establishes and maintains a register of patients with COPD	2	

Dementia (DEM)

Indicator	Points	Achievement thresholds
Records		
DEM001. The contractor establishes and maintains a register of patients diagnosed with dementia	2	

Ongoing management		
DEM002. The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 15 months	28	35–70%

Mental health (MH)

Indicator	Points	Achievement thresholds
Records		
MH001. The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy	2	
Ongoing management		
MH009. The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months *NICE 2010 menu ID: NM21*	1	50–90%
MH010. The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months *NICE 2010 menu ID: NM22*	2	50–90%
MH011W. The percentage of patients with schizophrenia, Bipolar affective disorder and other psychoses who have a record of blood pressure, BMI and alcohol consumption in the preceding 15 months and in addition for those aged 40 or over, a record of blood glucose or HbA1c in the preceding 15 months	12	45-85%

Disease register for mental health

Due to the way repeat prescribing works in general practice, patients on lithium therapy are defined as patients with a prescription of lithium within the preceding six months.

Remission from serious mental illness
Making an accurate diagnosis of remission can be challenging. In the absence of strong evidence of what constitutes ‘remission’ from serious mental illness, clinicians should only consider using the remission codes if the patient has been in remission for at least five years, that is where there is:

- no record of anti-psychotic medication

- no mental health in-patient episodes; and
- no secondary or community care mental health follow-up for at least five years.

Where a patient is recorded as being 'in remission' they remain on the MH001 register (in case their condition relapses at a later date) but they are excluded from the denominator for mental health indicators MH002, MH007 and MH011W.

The accuracy of this coding should be reviewed on an annual basis by a clinician. Should a patient who has been coded as 'in remission' experience a relapse then this should be recorded as such in their patient record.

In the event that a patient experiences a relapse and is coded as such, they will once again be included in all the associated indicators for schizophrenia, bipolar affective disorder and other psychoses.

Where a patient has relapsed after being recorded as being in remission, their care plan should be updated subsequent to the relapse. Care plans dated prior to the date of the relapse will not be acceptable for QOF purposes.

Cancer (CAN)

Indicator	Points	Achievement thresholds
Records		
CAN001. The contractor establishes and maintains a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers diagnosed on or after 1 April 2003'	2	
Ongoing management		
CAN003W. The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the contractor receiving confirmation of the diagnosis, or where clinically appropriate within 3 months. This patient review can be undertaken via a telephone consultation but with an offer of a face to face appointment. *NICE 2012 menu ID: NM62*	6	50–90%

Epilepsy (EP)

Indicator	Points	Achievement thresholds

Records		
EP001. The contractor establishes and maintains a register of patients aged 18 or over receiving drug treatment for epilepsy	1	

Learning disability (LD)

Indicator	Points	Achievement thresholds
Records		
LD001. The contractor establishes and maintains a register of patients with learning disabilities	2	

Osteoporosis: secondary prevention of fragility fractures

Indicator	Points	Achievement thresholds
Records		
OST001. The contractor establishes and maintains a register of patients: 1. Aged 50 or over and who have not attained the age of 75 with a record of a fragility fracture on or after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and 2. Aged 75 or over with a record of a fragility fracture on or after 1 April 2012 *NICE 2011 menu ID: NM29*	2	

Disease register for osteoporosis

Although the register indicator OST001 defines two separate registers, the disease register for the purpose of calculating the APDF is defined as the sum of the number of patients on both registers.

Rheumatoid arthritis (RA)

Indicator	Points	Achievement thresholds
Records		
RA001. The contractor establishes and maintains a register of patients aged 16 or over with rheumatoid arthritis	1	

NICE 2012 menu ID: NM55		

Palliative care (PC)

Indicator	Points	Achievement thresholds
Records		
PC001. The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age	3	

Disease register for palliative care

There is no APDF calculation in respect of the palliative care indicators. In the rare case of a nil register at year end, if a contractor can demonstrate that it established and maintained a register during the financial year then they will be eligible for payment for PC001.

Obesity (OB)

Indicator	Points	Achievement thresholds
Records		
OB001. The contractor establishes and maintains a register of patients aged 16 or over with a BMI ≥30 in the preceding 15 months	2	

Cervical screening (CS)

Indicator	Points	Achievement thresholds
CS001. The contractor has a protocol that is in line with national guidance agreed with the LHB for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate sample rates	2	
CS002. The percentage of women aged 25 or over and who have not attained the age of 65 whose notes record that a cervical screening test has been performed in the preceding 5 years	11	45–80%

Infuenza (FLU)

Indicator	Points	Achievement thresholds
FLU001W. The percentage of the registered population aged 65 years of more who have had influenza immunisation in the preceding 1 August to 31 March	5	55- 75%
FLU002W. The percentage of patients aged under 65 years included in (any of) the registers for CHD, COPD, Diabetes or Stroke who have had influenza immunisation in the preceding 1 August to 31 March	15	45- 65%

Medicines management

Indicator	Points
MED006W. The contractor meets the LHB prescribing advisor at least annually, has agreed up to three actions related to prescribing and subsequently provided evidence of change	8
MED007W. A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed 4 or more repeat medicines Standard 80%	10

Total active clinical QOF	**202**

Section 2.2 Clinical Domain inactive QOF

Diabetes mellitus (DM)

Indicator	Points	Achievement thresholds
Ongoing management		
DM002. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 mmHg or less *NICE 2010 menu ID: NM01*	8	
DM003. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 15 months) is 140/80 mmHg or less *NICE 2010 menu ID: NM02*	10	
DM007. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 15 months *NICE 2010 menu ID: NM14*	17	
DM 012 The percentage of patients with diabetes , on the register , with a record of a foot examination and risk classification; 1) low risk (normal sensation, palpable pulse) , 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 15 months *NICE 2010 menu ID : NM13*	4	
DM 014 The percentage of patients newly diagnoses with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register *NICE 2011 menu ID : NM27*	11	

Asthma (AST)

Indicator	Points	Achievement thresholds
Ongoing management		
AST004. The percentage of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, in whom there is a record of smoking status in the preceding 15 months	6	

Chronic obstructive pulmonary disease (COPD)

Indicator	Points	Achievement thresholds
Initial diagnosis		
COPD002. The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering on to the register	5	
Ongoing management		
COPD003. The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 15 months	9	
COPD005. The percentage of patients with COPD and Medical Research Council dyspnoea grade ≥3 at any time in the preceding 15 months, with a record of oxygen saturation value within the preceding 15 months *NICE 2012 menu ID: NM63*	5	

Mental health (MH)

Indicator	Points	Achievement thresholds
Ongoing management		
MH002. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a	6	

comprehensive care plan documented in the record, in the preceding 15 months, agreed between individuals, their family and/or carers as appropriate		
MH007. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months *NICE 2010 menu ID: NM15*	4	

Epilepsy (EP)

Indicator	Points	Achievement thresholds
Ongoing management		
EP003W. The percentage of women with epilepsy aged 18 or over and who have not attained the age of 55 who are taking antiepileptic drugs who have a record of being given information and advice about pregnancy or conception, or contraception tailored to their pregnancy and contraceptive intentions recorded in the preceding 3 years	2	

Rheumatoid arthritis (RA)

Indicator	Points	Achievement thresholds
Ongoing management		
RA002. The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 15 months *NICE 2012 menu ID: NM58*	10	

Palliative care (PC)

Indicator	Points	Achievement thresholds
Ongoing management		
PC002W. The contractor has regular (at least 2 monthly) multi-disciplinary case review meetings where all patients on the palliative care register are discussed	6	

Smoking (SMOK)

Indicator	Points	Achievement thresholds
Records		
SMOK002. The percentage of patients with any or any combination of the following conditions: CHD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 15 months *NICE 2011 menu ID: NM38*	25	
Ongoing management		
SMOK004. The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months *NICE 2011 menu ID: NM40*	12	
SMOK005. The percentage of patients with any or any combination of the following conditions: CHD, stroke or TIA, hypertension, diabetes, COPD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 15 months *NICE 2011 menu ID: NM39*	25	

Total inactive clinical QOF	**165**