D I R E C T I O N S

NATIONAL HEALTH SERVICE, ENGLAND

The General Medical Services Statement of Financial Entitlements (Amendment) Directions 2014

The Secretary of State for Health gives the following directions as to payments to be made under general medical services contracts in exercise of the powers conferred by sections 87, 272(7) and (8) and 273(1) of the National Health Service Act 2006(**a**).

In accordance with section 87(4) of that Act, the Secretary of State for Health has consulted the bodies appearing to the Secretary of State to be representative of persons to whose remuneration these Directions relate and has consulted such other persons as the Secretary of State for Health considers appropriate.

PART 1

General

Citation and commencement

1.—(1) These Directions may be cited as the General Medical Services Statement of Financial Entitlements (Amendment) Directions 2014.

(2) They come into force on 1st April 2014.

Interpretation

2. In these Directions, "the principal Directions" means the General Medical Services Statement of Financial Entitlements Directions 2013(**b**).

PART 2

Amendment to Part 1 of the principal Directions (global sum and minimum income practice guarantee)

Amendment of section 2 of the principal Directions

3. In section 2 of the principal Directions (global sum payments)—

(a) in paragraph 2.3 (calculation of a contractor's first Initial Global Sum Monthly Payment), for "£66.25" substitute "£73.56"; and

(**a**) 2006 (c.4); section 87 of the National Health Service Act 2006 ("the 2006 Act") was amended by section 55 of, and paragraph 33 of Schedule 4 to, the Health and Social Care Act 2012 (c.7). By virtue of section 271(1) of the 2006 Act, the powers conferred by these sections are exercisable by the Secretary of State only in relation to England.

(**b**) Those Directions were signed on 27th March 2013 and were amended by the General Medical Services Statement of Financial Entitlements (Amendment) Directions 2013 which were signed on 18th September 2013. Copies are available on the Department of Health website: www.gov.uk.

(b) in paragraph 2.5 (calculation of Adjusted Global Sum Monthly Payments), in column 2 of Table 1 (percentage of initial GSMP), for "6.0" substitute "5.46".

PART 3

Amendment of Part 2 of the principal Directions (Quality and Outcomes Framework)

Amendment to section 4 of the principal Directions

4. In section 4 of the principal Directions (general provisions relating to the quality and outcomes framework), in paragraph 4.8 (the principal domains of the QOF)—

(a) omit "four" from the heading;

(b) omit "four" after "divided into";

(c) add "and" at the end of sub-paragraph (a); and

(d) omit sub-paragraphs (c) and (d).

Amendment of section 6 of the principal Directions

5. In section 6 of the principal Directions (achievement payments: calculation, payment, arrangements and conditions of payment—

(a) in paragraph 6.7(b), for "001, 003" substitute "003"; and

(b) in paragraph 6.7(c), for "BP001" substitute "BP002".

PART 4

Amendment of Part 3 of the principal Directions (Directed Enhanced Services)

Amendment of section 7 of the principal Directions

6. In section 7 of the principal Directions (extended hours access scheme for the period 1st April 2013 to 31st March 2014)—

(a) in the heading, for "1st APRIL 2013 TO 31st MARCH 2014" substitute "1st APRIL 2014 TO 31st MARCH 2015";

(b) in paragraph 7.1, for the words beginning ""financial year" to the end of the paragraph substitute ""financial year" means the period commencing on 1st April 2014 and ending on 31st March 2015";

(c) in paragraph 7.2, for "31st March 2014" in sub-paragraph (a), substitute "31st March 2015";

(d) omit paragraph 7.5; and

(e) in paragraph 7.7, for "31st March 2014" substitute "31st March 2015".

Amendment of section 8 of the principal Directions

7. In section 8 of the principal Directions (alcohol related risk reduction scheme for the period 1st April 2013 TO 31st March 2014)—

(a) in the heading, for "1st APRIL 2013 TO 31st MARCH 2014" substitute "1st APRIL 2014 TO 31st MARCH 2015";

(b) in paragraph 8.1, for the words beginning ""financial year" to the end of the paragraph substitute ""financial year" means the period commencing on 1st April 2014 and ending on 31st March 2015";

(c) in paragraph 8.3—

(i) for “30th April 2014” substitute “30th April 2015”,

(ii) at the end of sub-paragraph (c) omit “and”,

(iii) after “the financial year” at the end of sub-paragraph (d) insert “;and;”; and

(iv) after sub-paragraph (d) insert—

“(e) the number of newly registered patients scoring between 8 and 19 on the full ten question AUDIT questionnaire who—

(i) have been identified as drinking at increasing or higher risk levels who have been assessed for depression and anxiety during the financial year,

(ii) have been offered screening for anxiety or depression,

(iii) have received screening for anxiety of depression,

(iv) are receiving ongoing support and treatment, or

(v) have been referred for specialist mental health services following screening for anxiety or depression.”;

(d) in paragraph 8.10, for “31st March 2014” substitute “31st March 2015”; and

(e) in paragraph 8.12, for “1st April 2013” substitute “1st April 2014”.

Amendment of section 9 of the principal Directions

8. In section 9 of the principal Directions (learning disabilities health check scheme for the period 1st April 2013 to 31st March 2014)—

(a) in the heading, for “1st APRIL 2013 TO 31st MARCH 2014” substitute “1st APRIL 2014 TO 31st MARCH 2015”;

(b) in paragraph 9.1, for the words beginning ““financial year” to the end of the paragraph substitute ““financial year” means the period commencing on 1st April 2014 and ending on 31st March 2015”;

(c) in paragraph 9.3, for “£102.16” substitute “£116.00”;

(d) in paragraph 9.5—

(i) for “31st March 2013” substitute “31st March 2014”, and

(ii) for sub-paragraphs (a) and (b) substitute—

“(a) that Health Check Learning Disabilities Register—

(i) may continue to be the agreed Register in respect of the financial year, and

(ii) must also have effect for the purpose of identifying those registered patients aged 14 years or over with learning disabilities who are to be invited for an annual health check; and

(b) there is no requirement to agree a further register.”;

(e) in paragraph 9.10, for “31st March 2014” substitute “31st March 2015”; and

(f) in paragraph 9.15 and its heading, for “31st March 2014” at both places substitute “31st March 2015”.

Amendment of section 10 of the principal Directions

9. In section 10 of the principal Directions (patient participation scheme)—

(a) in paragraph 10.1, for the words beginning “financial year” to end substitute “financial year” means the period commencing on 1st April 2014 and ending on 31st March 2015”; and

(b) for paragraphs 10.3 to section 10.30 substitute—

“Patient Participation Scheme Payments

10.3. If, as part of a GMS contract, a contractor and the Board have agreed arrangements for a Patient Participation Scheme in respect of the financial year, or any part thereof, a contractor must satisfy the requirement—

(a) to establish a Patient Participation Group comprising some of the registered patients and to use its best endeavours to ensure that its Patient Participation Group is representative of its registered patients (direction 11(7)(a) and (b) of the DES Directions); and

(b) to publish a report complying with direction 11(7)(h) and (i) of the DES Directions,

in the financial year.

10.4. Patient Participation Scheme Payments for GMS contractors referred to in paragraph 10.3 are to be calculated as follows—

(a) if only components 1 and 2 are completed, the sum payable is—

0.11xV

(b) if only components 1, 2, and 3 are completed, the sum payable is—

0.22xV, or

(c) if only components 1, 2, 3 and 4 are completed, the sum payable is—

0.36xV;

V is equal to—

(a) the contractor’s CRP as at 1st April 2014, or

(b) the contractor’s initial CRP if the contractor’s GMS contract was entered into after 1st April 2014.

10.5. For the purposes of paragraph 10.4, the reference to components means the requirements of the Patient Participation Scheme which comprise of, in respect of—

(a) component 1, the establishment of a Patient Participation Scheme comprising some of the registered patients and contractor using its best endeavours to ensure that the Patient Participation Group is representative of its registered patients (see direction 11(7)(a) and (b) of the DES Directions);

(b) component 2, the Patient Participation Group and contractor review patient feedback received by the practice (such as the National GP Patient Survey, review of complaints/suggestions and, when available, the results of the Friends and Family test) at a frequency agreed with the Patient Participation Group and reach agreement on changes to services with the practice;

(c) component 3, the contractor and Patient Participation Group develop an action plan for implementing changes based on at least three key priority areas;

(d) component 4, the contractor implements the improvements identified and publicises actions taken to the practice population including providing the Patient Participation Group with updates on progress and subsequent achievement. The contractor and Patient Participation Group are to complete a reporting template to report the actions taken during the year, involvement of the Patient Participation Group and how changes have benefited patients.

Accounting arrangements and due date for Patient Participation Scheme Payments

10.6. Patient Participation Scheme Payments are to be treated for accounting and superannuation purposes as gross income of the contractor in the financial year.

10.7. The amount calculated as the Patient Participation Scheme Payment falls due on the last day of the month following the month during which the contractor provides the information required under paragraph 10.3(b).

Conditions attached for payments

10.8. Patient Participation Scheme Payments, or any part thereof, are only payable if the contractor satisfies the following conditions—

(a) the contractor must make available to the Board any information which the Board does not have but needs, and the contractor either has or could be reasonably expected to obtain, in order to establish whether the contractor has fulfilled its obligation under the Patient Participation Scheme arrangements,

(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.

10.9. If the contractor breaches any of the conditions referred to in paragraph 10.8, the Board may, in appropriate circumstances, withhold payment of any, or any part of, a Patient Participation Scheme Payment that is otherwise payable.

Provisions relating to contractors whose contracts terminate or who withdraw from the arrangements in the financial year (subject to the provisions below for termination attributable to a practice split or merger)

10.10. Where—

(a) the contractor and the Board have agreed arrangements for the Patient Participation Scheme in respect of the financial year; and

(b) the contractor's contract subsequently terminates or the contractor withdraws from arrangements prior to 31st March 2015,

the contractor is entitled to a Patient Participation Scheme Payment in respect of its participation in the arrangements, calculated in accordance with the following provisions and any amount so calculated falls due on the last day of the month following the month during which the contractor provides the Board with a report using the agreed template and the information which enables the Board to be satisfied that the contractor has completed the relevant components.

10.11. In order to qualify for a Patient Participation Scheme Payment in respect of its participation in the arrangements, the contractor must, before the expiry of the period of 28 days from the date of termination of the contract or the date of withdrawal from the arrangements, provide the Board with report using the agreed template together with the necessary information from the Board to satisfy itself that the relevant components have been completed, in respect of the period commencing on 1st April 2014 and ending on the last day on which the contract remains in force or, where the contract remains in force but the contractor has withdrawn from the arrangements, on the last day on which the contractor was participating in the arrangements.

10.12. The Patient Participation Payment must be calculated, in a case where the contractor falls within paragraph 10.3, in accordance with paragraph 10.4.

Provisions relating to contractors whose practices merge during the financial year

10.13. Paragraphs 10.14 to 10.17 apply where two or more GMS contractors merge ("a contractual merger") and as a result two or more patient lists are combined resulting in either a new or varied GMS contract.

10.14. Assessment of any entitlement to a Patient Participation Scheme Payment will depend on whether or not the contractor under a new or varied GMS contract enters into new written arrangements before the expiry of the period of 28 days following the date on which the new or varied GMS contract commenced.

Mergers where new arrangements are entered into before the expiry of 28 days following the date on which a new or varied GMS contract commenced

10.15. Where there is a contractual merger and the contractor under a new or varied GMS contract does enter into new arrangements under the scheme before the expiry of 28 days following the date on which a new or varied GMS contract commenced, Patient Participation Scheme Payments or any part thereof are only payable—

(a) if the original contractor publishes the report using the agreed template on the website which the Board has determined to be the relevant website; or

(b) if the Board agrees, the original contractor provides the Board with a copy of that report.

10.16. No separate assessment is made in respect of entitlement under the original GMS contract that merged.

10.17. The entitlement of a contractor under the new or varied contract will be assessed in accordance with the provisions of this Section and on the basis set out in paragraph 10.4, and for the purposes of the calculation in that paragraph—

(a) V is the contractor's CRP as at the date on which the new or varied contract is entered into; and

(b) the Board is to deduct a sum if it has already been paid or is payable to one of the contractors whose contract is subject to the merger where the sum had been payable to the original contractor who entered into a Patient Participation Scheme arrangement and subsequently is a party to a contractual merger under which the new merged arrangements were entered into before 1st April 2015.

Mergers where no new arrangements are entered into before the expiry of 28 days following the date on which a new or varied GMS contract commenced

10.18. Where there is a contractual merger and the contractor under a new or varied GMS contract does not enter into new written arrangements under the scheme before the expiry of 28 days following the date on which a new or varied contract commenced—

(a) entitlement to any Patient Participation Scheme Payment arising under the original contracts will be assessed, on the basis that those contracts are treated as having terminated, in accordance with the provisions of this Section relating to contracts that terminate as set out in paragraphs 10.10 to 10.12; and

(b) where the contractor under a new or varied GMS contract subsequently enters into arrangements in respect of a Patient Participation Scheme Payment, the entitlement of the contractor under such arrangements will be assessed in accordance with the provisions of this Section but on the basis that—

(i) paragraph 10.4 applies and V is the contractor's CRP as at the date on which the new arrangements are entered into, and

(ii) the Board is to deduct a sum if it has already been paid or is payable to one of the contractors whose contract is subject to the merger where the sum had been paid or is payable to the original contractor who entered into a Patient Participation Scheme arrangements and subsequently is a party to a contractual merger under which the new merged arrangements were entered into before 1st April 2015.

Provisions relating to contractors whose practices split in the financial year

10.19. Paragraphs 10.20 to 10.23 apply where a GMS contractor splits ("a contractual split"), and as a result the contractor's patient list is divided between two or more GMS contractors, resulting in either new GMS contracts or varied GMS contracts or a combination of both.

10.20. Unless paragraph 10.23 applies, where there is a contractual split, the GMS contract that splits will be treated as having terminated on the date on which the contract splits and any entitlement to a Patient Participation Scheme Payment arising under the original contract will be assessed in accordance with paragraphs 10.10 to 10.12.

10.21. Assessment of any entitlement under any new or varied GMS contracts arising out of a contractual split to a Patient Participation Payment depends on whether or not the contractor under its new or varied GMS contract enters into new written arrangements before the expiry of 28 days following the date on which the new or varied GMS contract commenced.

10.22. Where there is a contractual split and a contractor under any new or varied contract enters into new written arrangements under the Scheme before the expiry of 28 days following the date on which the new or varied GMS contract commenced, the entitlement of the contractor entering into the new or varied contract to a Patient Participation Scheme Payment will be assessed in accordance with the provisions of this Section, on the basis of paragraph 10.15 to 10.17.

10.23. Where there is a contractual split and a contractor under a new or varied GMS contract does not enter into new written arrangements under the Scheme before the expiry of 28 days following the date on which the new or varied GMS contract commenced, but subsequently enters into such arrangements, the entitlement of the contractor entering into the new or varied contract to a Patient Participation Scheme Payment is to be assessed in accordance with the provisions in paragraph 10.18(b).

Provisions relating to non standard splits and mergers

10.24. Where a GMS contractor who has entered into Patient Participation Scheme arrangements with the Board is subject to a split or a merger and—

(a) the application of the provisions set out in this Section in respect of splits or mergers would, in the reasonable opinion of the Board, lead to an inequitable result, or

(b) the circumstances of the split or merger are such that the provisions set out in this Section cannot be applied,

the Board may, in consultation with the contractor or contractors concerned, agree to such payments as in the Board's opinion, are reasonable in all the circumstances.".

Amendment of section 11 of the principal Directions

10. In section 11 of the principal Directions (childhood immunisations), for "58" in paragraph 11.20 substitute "61".

PART 5

Amendment of Part 4 of the principal Directions (payments for specific purposes)

Amendment of section 12 of the principal Directions

11. In section 12 of the principal Directions (rotavirus vaccine), for "£7.63" in paragraph 12.3 substitute "£7.64".

Amendment of section 14 of the principal Directions

12. In section 14 of the principal Directions (shingles immunisation programme), for paragraph 14.2 substitute—

"**14.2.** The Board must pay a payment of £7.64 in respect of each registered patient of the contractor—

(a) who—

(i) has attained the age of 70 years by 1st September 2013 but who has not yet attained the age of 71 years; and

(ii) receives the Shingles vaccine during the period between 1st April 2014 and 31st August 2014; or

(b) who—

(i) attains the age of 70 years by 1st September 2014 but who will not attain the age of 71 by 31st March 2015**;** and

(ii) receives the Shingles vaccine between 1st September 2014 and 31st March 2015.".

Insertion of section 14A into the principal Directions

13. After section 14 of the principal Directions (shingles immunisation programme) insert—

"**Section 14A: MMR VACCINE FOR PERSONS AGED 16 AND OVER**

14A.1. This Section makes provision in respect of the payments to be made in respect of the administration by a contractor, which is contracted to provide vaccines and immunisations as part of Additional Services of up to two doses of the MMR vaccine as part of the MMR Immunisation Programme.

14A.2. The Board must pay to the contractor who qualifies for the payment, a payment of £7.64 for each dose of the MMR vaccine which is administered to a registered patient aged 16 or over who has not previously received a completed course of MMR vaccination.

14A.3. Two doses of the MMR vaccine may be administered to a patient referred to in paragraph 14A.2 if—

(a) the contractor considers that this is clinically necessary in order to provide the patient with protection; or

(b) the patient's vaccination status is unknown,

provided that there is an interval of at least four weeks between the administration of each dose.

Eligibility for payment

14A.4. A contractor is only eligible for a payment under this Section in circumstances where the following conditions are met—

(a) the contractor is contracted to provide vaccine and immunisations as part of Additional Services;

(b) the patient in respect of whom the payment is claimed was on the contractor's list of registered patients at the time the vaccine was administered;

(c) the contractor administers the vaccine to the patient in respect of whom the payment is claimed;

(d) the patient in respect of whom the payment is claimed is a person who falls within the Target Group referred to in paragraph 14A.2 when the vaccine is administered;

(e) the contractor does not receive any payment from any other source in respect of the vaccine (if the contractor does receive any such payment in respect of any patient from any other source, the Board must give serious consideration to recovering any payment made under this Section in respect of that patient pursuant to paragraphs 25.1 and 25.2 (overpayments and withheld amounts); and

(f) the contractor submits the claim within 6 months of administering the vaccine.

14A.5. The Board may set aside the requirement that the contractor submit the claim within 6 months of administering the vaccine if it considers it reasonable to do so.

Claims for payment

14A.6. The contractor is to submit claims in respect of the final completing dose of the vaccine after they have been administered at a frequency to be agreed between the Board and the contractor (which must be a frequency which provides for the claim to be submitted within 6 months of administering the final completing vaccination), or if agreement cannot be reached, within 14 days of the end of the month during which the final completing course of the vaccine was administered. Any amount payable falls due on the next date, following the expiry of 14 days after the claim is submitted, when the contractor's Payable GSMP falls due.

14A.7. The Board must ensure that the receipt and payment in respect of any claims are properly recorded and that each such claim has a clear audit trail.

Conditions attached to payment

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

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

(i) the name of the patient,

(ii) the date of birth of the patient,

(iii) the NHS number, where known, of the patient,

(iv) confirmation that the patient has received the vaccine in accordance with paragraph 14A.2; and

(v) the date on which the vaccine was administered by the contractor,

but, where the patient objects to details of the patient's name or date of birth being supplied to the Board, the contractor need not supply such information to the Board but must supply the patient's NHS number;

(b) the contractor must provide appropriate information and advice to the patient about the vaccine and immunisation;

(c) the contractor must record in the patient's records, kept in accordance with paragraph 73 of Schedule 6 to the 2004 Regulations, any refusal of an offer of the MMR vaccine;

(d) where the MMR vaccine is administered, the contractor must record in the patient's records kept in accordance with paragraph 73 of Schedule 6 to the 2004 Regulations, those matters set out in paragraph 4(3)(e) of Schedule 2 to the 2004 Regulations;

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

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

(g) the contractor must make any returns required of it (whether computerised or otherwise) to the Exeter Registration System, and do so promptly and fully; and

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

14A.9. If the contractor breaches any of these conditions, the Board may, in appropriate circumstances, withhold payment of all or any part of any payment due under this Section.

Section 14B: HEPATITIS B VACCINATION FOR BABIES

14B.1. This section makes provision in respect of payments to be made in respect of the administration by a contractor, which is contracted to provide vaccines and immunisations as part of Additional Services, of the Hepatitis B vaccination to babies, as part of the Hepatitis B Immunisation Programme.

14B.2. The Board must pay to the contractor who qualifies for the payment, a payment of £7.64 in respect of each dose administered to a baby who is on the registered list of patients and who is born to a mother who is infected with Hepatitis B

14B.3. The contractor must not administer the Hepatitis B vaccination to a baby in any case where the Hepatitis B status of the mother is unknown.

14B.4. The first dose of the Hepatitis B vaccine is to be administered by the contractor to a baby—

(a) only if it has not already been administered by a hospital immediately after the birth of the baby; and

(b) as soon as possible after the birth of the baby.

14B.5. The second dose of the Hepatitis B vaccine is to be administered by the contractor to a baby—

(a) who has attained the age of one month; or

(b) after the period of at least four weeks from the date on which the first dose was administered.

14B.6. The third dose of the Hepatitis B vaccine is to be administered by the contractor to a baby—

(a) who has attained the age of two months; or

(b) after the period of at least four weeks from the date on which the second dose was administered.

14B.7. The fourth dose of the Hepatitis B vaccine may only be administered by the contractor to a baby who has attained the age of 12 months.

Claims for Payment

14B.8. A contractor may not claim a payment for the administration by the contractor of the second dose of the Hepatitis B vaccine to a baby unless the contractor has also administered the third dose of the vaccine to that baby.

14B.9. A contractor may not claim a payment for the administration of the fourth dose of the Hepatitis B vaccine to a baby unless the contractor has recorded the results in the baby's patient record of a blood test to ascertain the existence of Hepatitis B infection.

14B.10. A contractor is eligible for a payment in respect of the administration of the Hepatitis B vaccine to a baby in any case where the vaccine status of the baby is unknown or incomplete and the contractor completes the administration of the required doses of the Hepatitis B vaccine to that baby.

14B.11. Claims for payment must be submitted within 6 months of the administration of the final completing vaccination or, if agreement cannot be reached, within 14 days of the end of the month during which the final completing course of the vaccine was administered. Any amount payable falls due on the next date, following the expiry of 14 days after the claim is submitted, when the contractor's Payable GSMP falls due.

14B.12. The Board must ensure that the receipt and payment in respect of claims are properly recorded and that each such claim has a clear audit trail.

Eligibility for payment

14B.13. A contractor is only eligible for a payment under this Section in circumstances where the following conditions are met—

(a) the contractor is contracted to provide vaccines and immunisations as part of Additional Services;

(b) the baby in respect of whom the payment is claimed was on the contractor's list of registered patients at the time the vaccine was administered;

(c) the contractor does not receive any payment from any other source in respect of the vaccine (if the contractor does receive any such payment in respect of any baby from any other source, the Board must give serious consideration to recovering any payment made under this Section in respect of that patient pursuant to paragraphs 25.1 and 25.2 (overpayments and withheld amounts)); and

(d) the contractor submits the claim for payment—

(i) within 6 months of administering the first dose of the vaccine,

(ii) within 6 months of administering the third dose of the vaccine (which is dependent of the second dose of the vaccine having been administered), or

(iii) within 6 months of administering the fourth dose of the vaccine.

Conditions attached to payment

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

(a) the contractor must supply the Board in respect of each baby for which a payment is claimed—

(i) the name of the baby,

(ii) the date of birth of the baby,

(iii) the NHS number, where known, of the baby;

(iv) confirmation that the baby has received the required doses of the hepatitis B vaccine in accordance with paragraph 14B.4 to 14B.7,

(v) the date on which each dose of the vaccine was administered by the contractor,

but where a parent or carer objects to details of the baby's name or date or birth being supplied to the Board, the contractor need not supply such information to the Board but must supply the baby's NHS number;

(b) the contractor must provide appropriate information and advice to the parent or carer of the baby;

(c) the contractor must record in the baby's records, kept in accordance with paragraph 73 of Schedule 6 to the 2004 Regulations, any refusal of an offer of the Hepatitis B vaccine;

(d) where the Hepatitis B vaccine is administered, the contractor must record in the baby's records, kept in accordance with paragraph 73 of Schedule 6 to the 2004 Regulations, those matters set out in paragraph 5(2)(d) of Schedule 2 to the 2004 Regulations;

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

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

(g) 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

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

14B.15. If the contractor breaches any of these conditions, the Board may, in appropriate circumstances, withhold payment of any, or any part of, the payment due under this Section.".

Amendment of section 19 of the principal Directions

14. In section 19 of the principal Directions (seniority payments)—

(a) for paragraph 19.1 (general) substitute—

"**19.1.** Seniority payments are—

(a) payments to a contractor in respect of individual GP providers in eligible posts to reward experience, based on years of Reckonable Service; and

(b) to cease to be paid—

(i) after 31st March 2014, to any contractor who is not entitled to receive such payments at that date; and

(ii) on 31st March 2020 to all contractors.";

(b) in paragraph 19.12 (calculation of the full rate of Seniority Payments), in the second column of the table (full annual rate of payment per practitioner), for "600" substitute "0".

PART 6

Amendment to Annex A (Glossary)

Amendment to Part 2 of Annex A

15. In Part 2 of Annex A (definitions), for the definition of "DES Directions" substitute—

""DES Directions" means the Primary Medical Services (Directed Enhanced Services Directions) 2014 signed on 31st March 2014;".

PART 7

Amendment to Annex B (Global Sum)

Amendment to Part 2 of Annex B to the principal Directions

16. In Part 2 of Annex B to the principal Directions (vaccines and immunisations)—

(a) in column 1 of Table 1 (vaccines and immunisations in respect of diseases), after the entry in respect of measles, mumps and rubella, insert—

"5. Meningococcal Vaccine (MenC)"; and

(b) in column 2 of Table 1 (circumstances in which vaccines or immunisations is to be offered and given), immediately opposite the entry in column 1 in respect of meningococcal vaccine (MenC), insert—

"(a) Children under 6 years should be offered meningococcal immunisation in accordance with the Childhood Immunisation Scheme (as referred to in paragraph 11.2) and offered the pneumococcal and Hib/MenC booster vaccine in accordance with Section 13.

(b) Persons who have attained the age of 6 years but who have not yet attained the age of 25 years who have not previously been immunised with conjugate meningococcal C vaccine, or whose immunisation history is incomplete or unknown, are to be offered one dose of conjugate meningococcal C vaccine.

(c) Persons who attain the age of 25 years in the period commencing 1st April 2014 and ending 31st March 2015 who have not previously been immunised with conjugate meningococcal C vaccine, or whose immunisation history is incomplete or unknown, are to be offered one dose of conjugate meningococcal C vaccine.".

PART 8

Amendment of Annex D (Quality and Outcomes Framework)

Amendment of section 2 of Annex D to the principal Directions

17. In section 2 of Annex D of the principal Directions (summary of QOF indicators)—

(a) for sections 2.1 (clinical domain) and 2.2 (public health domain) substitute the text in Schedule 1; and

(b) omit sections 2.3 and 2.4.

PART 9

Amendment of Annex F (adjusted practice disease factor calculations)

18. In Annex F to the principal Directions (adjusted disease factor calculations)—

(a) in paragraph F1(a)—

(i) for "BP001" substitute "BP002", and

(ii) omit "SMOK001";

(b) in paragraph F4.1(a) omit "the Quality and Outcome Framework Management and Analysis System (QMAS) or upon the closure of QMAS,"; and

(c) in paragraph F5—

(i) for "BP001" substitute "BP002", and

(ii) omit “SMOK001”.

Signed by authority of the Secretary of State for Health

GARETH ARTHUR
Member of the Senior Civil Service
Department of Health

Date 28 March 2014

SCHEDULE 1

Revised text of section 2 of Annex D to the principal directions

Section 2: Summary of QOF indicators

Section 2.1: Clinical domain (435 points)

Section 2.1.applies to all contractors participating in QOF.

Atrial fibrillation (AF)

Indicator	Points	Achievement thresholds
Records		
AF001. The contractor establishes and maintains a register of patients with atrial fibrillation	5	
Ongoing management		
AF005. In those patients with atrial fibrillation in whom there is a record of a $CHADS_2$ score of 1, the percentage of patients who are currently treated with anti-coagulation drug therapy or anti-platelet therapy *Based on NICE 2011 menu ID: NM45*	6	57–97%
AF004. In those patients with atrial fibrillation whose latest record of a $CHADS_2$ score is greater than 1, the percentage of patients who are currently treated with anti-coagulation therapy *Based on NICE 2011 menu ID: NM46*	6	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	4	
Ongoing management		
CHD002. The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	17	53–93%
CHD005. The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken	7	56–96%

CHD006. The percentage of patients with a history of myocardial infarction (on or after 1 April 2011) currently treated with an ACE-I (or ARB if ACE-I intolerant), aspirin or an alternative anti-platelet therapy, beta-blocker and statin *NICE 2010 menu ID: NM07*	10	60–100%
CHD007. The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 August to 31 March	7	56–96%

Heart failure (HF)

Indicator	Points	Achievement thresholds
Records		
HF001. The contractor establishes and maintains a register of patients with heart failure	4	
Initial diagnosis		
HF002. The percentage of patients with a diagnosis of heart failure (diagnosed on or after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment 3 months before or 12 months after entering on to the register	6	50–90%
Ongoing management		
HF003. In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB	10	60–100%
HF004. In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction who are currently treated with an ACE-I or ARB, the percentage of patients who are additionally currently treated with a beta-blocker licensed for heart failure	9	40–65%

Disease registers for heart failure

There are two disease registers used for the HF indicators for the purpose of calculating APDF (practice prevalence):

1. a register of patients with HF is used to calculate APDF for HF001 and HF002,
2. a register of patients with HF due to left ventricular systolic dysfunction (LVSD) is used to calculate APDF for HF003 and HF004.

Register 1 is defined in indicator HF001. Register 2 is a sub-set of register 1 and is composed of patients with a diagnostic code for LVSD as well as for HF.

Hypertension (HYP)

Indicator	Points	Achievement thresholds
Records		
HYP001. The contractor establishes and maintains a register of patients with established hypertension	6	
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	20	45–80%

Peripheral arterial disease (PAD)

Indicator	Points	Achievement thresholds
Records		
PAD001. The contractor establishes and maintains a register of patients with peripheral arterial disease *NICE 2011 menu ID: NM32*	2	
Ongoing management		
PAD002. The percentage of patients with peripheral arterial disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less *NICE 2011 menu ID: NM34*	2	40–90%
PAD004. The percentage of patients with peripheral arterial disease with a record in the preceding 12 months that aspirin or an alternative anti-platelet is being taken *NICE 2011 menu ID: NM33*	2	40–90%

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	
Initial diagnosis		
STIA008. The percentage of patients with a stroke or TIA (diagnosed on or after 1 April 2014) who have a record of a referral for further investigation between 3 months before or 1 month after the date of the latest recorded stroke or the first TIA	2	45–80%

Ongoing management		
STIA003. The percentage of patients with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	5	40–75%
STIA007. The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 12 months that an anti-platelet agent, or an anti-coagulant is being taken	4	57–97%
STIA009. The percentage of patients with stroke or TIA who have had influenza immunisation in the preceding 1 August to 31 March	2	55–95%

Diabetes mellitus (DM)

Indicator	Points	Achievement thresholds
Records		
DM017. 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*	6	
Ongoing management		
DM002. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less *NICE 2010 menu ID: NM01*	8	53–93%
DM003. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less *Based on NICE 2010 menu ID: NM02*	10	38–78%
DM004. The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less	6	40–75%
DM006. The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs)	3	57–97%
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 12 months *NICE 2010 menu ID: NM14*	17	35–75%
DM008. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months	8	43–83%

DM009. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months	10	52–92%
DM012. 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 pulses), 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 12 months *NICE 2010 menu ID: NM13*	4	50–90%
DM014. The percentage of patients newly diagnosed 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	40–90%
DM018. The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 August to 31 March	3	55–95%

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	4	
Initial diagnosis		
AST002. The percentage of patients aged 8 or over with asthma (diagnosed on or after 1 April 2006), on the register, with measures of variability or reversibility recorded between 3 months before or any time after diagnosis	15	45–80%
Ongoing management		
AST003. The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions *NICE 2011 menu ID: NM23*	20	45–70%
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 12 months	6	45–80%

Chronic obstructive pulmonary disease (COPD)

Indicator	Points	Achievement thresholds
Records		
COPD001. The contractor establishes and maintains a register of patients with COPD	3	
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	45–80%
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 12 months	9	50–90%
COPD004. The percentage of patients with COPD with a record of FEV_1 in the preceding 12 months	7	40–75%
COPD005. The percentage of patients with COPD and Medical Research Council dyspnoea grade ≥3 at any time in the preceding 12 months, with a record of oxygen saturation value within the preceding 12 months *NICE 2012 menu ID: NM63*	5	40-90%
COPD007. The percentage of patients with COPD who have had influenza immunisation in the preceding 1 August to 31 March	6	57-97%

Dementia (DEM)

Indicator	Points	Achievement thresholds
Records		
DEM001. The contractor establishes and maintains a register of patients diagnosed with dementia	5	
Ongoing management		
DEM002. The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months	15	35–70%
DEM003. The percentage of patients with a new diagnosis of dementia recorded in the preceding 1 April to 31 March with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels	6	45–80%

recorded between 6 months before or after entering on to the register *NICE 2010 menu ID: NM09*		

Depression (DEP)

Indicator	Points	Achievement thresholds
Initial management		
DEP003. The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis *Based on NICE 2012 menu ID: NM50*	10	45–80%

Disease register for depression

There is no register indicator for the depression indicator. The disease register for the depression indicator for the purpose of calculating the APDF is defined as all patients aged 18 or over, diagnosed on or after 1 April 2006, who have an unresolved record of depression in their patient record.

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	4	
Ongoing management		
MH002. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate	6	40–90%
MH003. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months *NICE 2010 menu ID: NM17*	4	50–90%
MH007. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months *NICE 2010 menu ID: NM15*	4	50–90%

MH008. The percentage of women aged 25 or over and who have not attained the age of 65 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years *NICE 2010 menu ID: NM20*	5	45–80%
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%

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, MH003, MH007 and MH008.

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 again be included in all the associated indicators for schizophrenia, bipolar affective disorder and other psychoses and their care plan should be updated.

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'	5	
Ongoing management		
CAN003. 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 date of diagnosis *Based on NICE 2012 menu ID: NM62*	6	50–90%

Chronic kidney disease (CKD)

Indicator	Points	Achievement thresholds
Records		
CKD001. The contractor establishes and maintains a register of patients aged 18 or over with CKD (US National Kidney Foundation: Stage 3 to 5 CKD)	6	
Ongoing management		
CKD002. The percentage of patients on the CKD register in whom the last blood pressure reading (measured in the preceding 12 months) is 140/85 mmHg or less	11	41–81%
CKD003. The percentage of patients on the CKD register with hypertension and proteinuria who are currently treated with an ACE-I or ARB	9	45–80%
CKD004. The percentage of patients on the CKD register whose notes have a record of a urine albumin:creatinine ratio (or protein:creatinine ratio) test in the preceding 12 months	6	45–80%

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		
LD003. The contractor establishes and maintains a register of patients with learning disabilities	4	

Osteoporosis: secondary prevention of fragility fractures (OST)

Indicator	Points	Achievement thresholds
Records		
OST004 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 2014 and a diagnosis of osteoporosis *NICE 2011 menu ID: NM29*	3	
Ongoing management		
OST002. The percentage of patients aged 50 or over and who have not attained the age of 75, with a fragility fracture on or after 1 April 2012, in whom osteoporosis is confirmed on DXA scan, who are currently treated with an appropriate bone-sparing agent *NICE 2011 menu ID: NM30*	3	30–60%
OST005. The percentage of patients aged 75 or over with a record of a fragility fracture on or after 1 April 2014 and a diagnosis of osteoporosis, who are currently treated with an appropriate bone-sparing agent *NICE 2011 menu ID: NM31*	3	30–60%

Disease register for osteoporosis

Although the register indicator OST004 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 *NICE 2012 menu ID: NM55*	1	

Ongoing management		
RA002. The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 12 months *NICE 2012 menu ID: NM58*	5	40–90%

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	
Ongoing management		
PC002. The contractor has regular (at least 3 monthly) multi-disciplinary case review meetings where all patients on the palliative care register are discussed	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.

Section 2.2: Public health domain (124 points)

Section 2.2.1: Public health domain

Section 2.2.1. applies to all contractors participating in QOF.

Cardiovascular disease – primary prevention (CVD-PP)

Indicator	Points	Achievement thresholds
Ongoing management		
CVD-PP001. In those patients with a new diagnosis of hypertension aged 30 or over and who have not attained the age of 75, recorded between the preceding 1 April to 31 March (excluding those with pre-existing CHD, diabetes, stroke and/or TIA), who have a recorded CVD risk assessment score (using an assessment tool agreed with the NHS CB) of ≥20% in the preceding 12 months: the percentage who are currently treated with statins *NICE 2011 menu ID: NM26*	10	40–90%

Disease register for CVD-PP

The disease register for the purpose of calculating the APDF for the CVD-PP indicator is defined as "patients diagnosed in the preceding 12 months with a first episode of hypertension, excluding patients with the following conditions:

- CHD or angina
- stroke or TIA
- peripheral vascular disease
- familial hypercholesterolemia
- diabetes
- CKD (US National Kidney Foundation: Stage 3 to 5 CKD).

Blood pressure (BP)

Indicator	Points	Achievement thresholds
BP002. The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years *NICE 2012 menu ID: NM61*	15	50–90%

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 12 months	8	

Smoking (SMOK)

Indicator	Points	Achievement thresholds
Records		
SMOK002. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months *NICE 2011 menu ID: NM38*	25	50–90%
Ongoing management		
SMOK003. The contractor supports patients who smoke in stopping smoking by a strategy which includes providing	2	

literature and offering appropriate therapy		
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 24 months *Based on NICE 2011 menu ID: NM40*	12	40–90%
SMOK005. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 months *NICE 2011 menu ID: NM39*	25	56–96%

Disease register for smoking

The disease register for the purpose of calculating the APDF for SMOK002 and SMOK005 is defined as the sum of the number of patients on the disease registers for each of the conditions listed in the indicators. Any patient who has one or more co-morbidities e.g. diabetes and CHD, is only counted once on the register for SMOK002 and SMOK005.

There is no APDF calculation for SMOK003 and SMOK004.

Requirements for recording smoking status

Smokers
For patients who smoke this recording should be made in the preceding 12 months for SMOK002.

Non-smokers
It is recognised that life-long non-smokers are very unlikely to start smoking and indeed find it quite irritating to be asked repeatedly regarding their smoking status. Smoking status for this group of patients should be recorded in the preceding 12 months for SMOK002 until the end of the financial year in which the patient reaches the age of 25.

Once a patient is over the age of 25 years (e.g. in the financial year in which they reach the age of 26 or in any year following that financial year) to be classified as a non-smoker they should be recorded as:

- never smoked which is both after their 25th birthday and after the earliest diagnosis date for the disease which led to the patients inclusion on the SMOK002 register (e.g. one of the conditions listed on the SMOK002 register).

Ex-smokers
Ex-smokers can be recorded as such in the preceding 12 months for SMOK002. Practices may choose to record ex-smoking status on an annual basis for three consecutive financial years and after that smoking status need only be recorded if there is a change. This is to recognise that once a patient has been an ex-smoker for more than three years they are unlikely to restart.

Section 2.2.2: Public health (PH) domain – additional services sub domain

Section 2.2.2. applies to contractors who provide additional services under the terms of the GMS contract and participate in QOF.

Cervical screening (CS)

Indicator	Points	Achievement thresholds
CS001. The contractor has a protocol that is in line with national guidance agreed with the NHS CB 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	7	
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%
CS004. The contractor has a policy for auditing its cervical screening service and performs an audit of inadequate cervical screening tests in relation to individual sample-takers at least every 2 years	2	

Contraception (CON)

Indicator	Points	Achievement thresholds
CON001. The contractor establishes and maintains a register of women aged 54 or under who have been prescribed any method of contraception at least once in the last year, or other clinically appropriate interval e.g. last 5 years for an IUS	4	
CON003. The percentage of women, on the register, prescribed emergency hormonal contraception one or more times in the preceding 12 months by the contractor who have received information from the contractor about long acting reversible methods of contraception at the time of or within 1 month of the prescription	3	50–90%