GUIDE TO CODING AND
DISEASE REGISTERS FOR THE
CONTRACT

Updated July 2011
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The following guidance discusses the effect of recent changes to the Quality and Outcomes Framework (QOF) on disease populations and indicators. It takes account of recent changes to the specifications for 2011-12 and the recent upgrade to V20 of the code and search specifications issued to software systems in June 2011. These changes are highlighted in red. There is advice on issues that may need consideration in respect of practice coding and recording of data. The SCIMP website also lists the complete Contract v20 Read codes:-
http://www.scimp.scot.nhs.uk/coding_guidance.html

Useful additional information can be obtained from:-
- There are links to the full official guidance for the QOF plus documentation of the changes made for 2011-12.

http://www.pcc.nhs.uk/business-rules-v20.0
- details the latest published Department of Health technical dataset and business rules documents. These define in detail which Read codes are valid, the relevant timescales and the searches used by QMAS.

Specific advice on exception coding can be found at:-

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**ASTHMA**

**Population (Asthma1)** – *The practice can produce a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the preceding 12 months*

**Points** 4

- Patients require an appropriate Read Code and an asthma medication prescription within the last year.
- V20 - codes H333. (Acute exacerbation of asthma) and H33z1 (Asthma attack) now included in diagnosis codes.
- V20 – minor amendments to drug searches to exclude drugs that are now discontinued.
- It is possible to remove patients from the population by using one of the Asthma resolved codes. This is required to be dated after the most recent Asthma Read code.

It is now accepted that patients can have co-existing Asthma and COPD and therefore may be on both registers.

**Indicators**

**ASTHMA 8** – *‘The percentage of patients aged 8 years and over diagnosed as having asthma from 1 April 2006 with measures of variability or reversibility.’*

Range 40-80%

**Points** 15

- This indicator now specifies that the diagnosis tests should include measures of variability or reversibility. This applies particularly to spirometry and it should be noted that there is now a much smaller group of acceptable spirometry codes in Asthma compared with COPD. Care will be needed in patients who have both conditions. The register starts from 1.4.06 therefore there is no need to review the coding of patients diagnosed before this.
- V20 added code 745D4 (Post bronchodilator spirometry) to spirometry codes and code 33950 (Diurnal variation of peak expiratory flow rate) to PEFR codes

**ASTHMA 3** – *‘The percentage of patients with asthma between the ages of 14 and 19 years in whom there is a record of smoking status in the preceding 15 months.’*

Range 40-80%

**Points** 6

- This indicator is the same as in 2007 – 08. Patients with Asthma are included in the indicators Smoking 3 and 4. The Asthma exception codes do not apply for the Smoking 3 and 4 indicators. There are separate ‘Smoking’ exception codes that can be used.

**ASTHMA 6** – *‘The percentage of patients with asthma who have had an asthma review in the preceding 15 months.’*

Range 40-70%

**Points** 20

- Unchanged from 2008 – 09.
**ATRIAL FIBRILLATION**

**Population (AF1)** - The Practice can produce a register of patients with atrial fibrillation.

**Points 5**

- Codes for both Atrial Fibrillation and Paroxysmal AF are included. Patients can be coded as AF resolved and will be excluded from the population if this is dated after the most recent ‘AF’ code.
- There are overall exception codes available for patient unsuitable and informed dissent.

**Indicators**

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

*Range 40-90%*

**Points 10**

- Codes for the diagnosis of AF need to be entered within 3 months before to 3 months after the ‘AF’ code.
- Care may be needed in the coding of ECG as not all ECG codes will be recognised by the Contract searches. Please check the code list.

**AF3.** The percentage of patients with atrial fibrillation who are currently treated with anti-coagulant drug therapy or an anti-platelet therapy.

*Range 40-90%*

**Points 12**

Prescriptions should be recorded in the previous 6 months and can be any one of Salicylates, Warfarin, Clopidogrel or Dipyridamole. Codes for OTC salicylates still apply.

- To exception code from this indicator an exception code for each of the 4 different drugs needs to be entered within the appropriate time scale (some codes are permanent and some expire after 15 months).
**Population Cancer1.** – The practice can produce a register of all cancer patients defined as a ‘register of patients with a diagnosis of cancer excluding non-melanotic skin cancers from 1st April 2003’.

*Points 5*

This indicator remains unchanged from 2007-08. The register is for all new patients since 1.4.03.

- V20 New read code within current diagnosis code groups - B627E Diffuse large B-cell lymphoma

**Indicators**

**Cancer3** ‘The percentage of patients with cancer, diagnosed within the preceding 18 months, who have a patient review recorded as occurring within 6 months of the practice receiving confirmation of the diagnosis’

*Range 40-90%*

*Points 6*

- This indicator only applies for new diagnosis in the last 18 months.
- The review code requires entry within the previous 12 months and also within 6 months of the first occurrence of the Cancer code. It is possible that some patients diagnosed 12-18 months ago may have a review code more than 12 months ago. These reviews will not count for the year 2010-11 but will have been included in 2009-10
- A new diagnosis in the last 6 months will be excluded if no review has been done. This allows the full 6 months in which to do a review. These patients will count for the following year so a review is still required within the 6 month period.
CORONARY HEART DISEASE

Population CHD1 – The practice can produce a register of patients with Coronary Heart Disease.
Points 4

Indicators

- Patients with CHD are included in the indicators Smoking 3 and 4. The CHD exception codes do not apply and there are separate ‘Smoking’ exception codes that can be used.
- Although not an indicator within CHD, patients with CHD are required to be assessed for possible depression using the 2 standard questions (see Depression). For assessment of depression the CHD exception codes do not apply and there are separate ‘Depression’ exception codes that can be used.

CHD 2: The percentage of patients with newly diagnosed angina (diagnosed after 1 April 2003) who are referred for exercise testing and/or specialist assessment.
Removed – replaced by CHD13

CHD13: For patients with newly diagnosed angina (diagnosed after 1 April 2011), the percentage who are referred for specialist assessment.
Range 40-90%
Points 7
- this replaces the old Indicator CHD2. Care needed as codes for exercise tolerance testing are no longer accepted
- Referral codes require entry within the time scale of 3 months before to 12 months after the earliest angina code (if this is after 1.4.11).
- No exception coding now available for this indicator (codes used for CHD2 removed)

CHD5 – The percentage of patients with Coronary Heart Disease, whose notes have a record of blood pressure in the previous 15 months. Removed

CHD6 - The percentage of patients with Coronary Heart Disease, in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 or less.
Range 40-71%
Points 17
- Exception codes exist for blood pressure procedure refused and on maximal tolerated hypertensive treatment.

CHD7 – The percentage of patients with Coronary Heart Disease whose notes have a record of total cholesterol in the previous 15 months. Removed

CHD8 - The percentage of patients with Coronary Heart Disease whose last measured total cholesterol (measured in the preceding 15 months) is 5mmol/l or less.
Range 40-70%
Points 17
- The codes (and exception codes) remain the same as for 2010 –11.
CHD9 - The percentage of patients with Coronary Heart Disease with a record in the preceding 15 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken (unless a contraindication or side effects are recorded).
Range 40-90%
Points 7
- This indicator is unchanged from 2010-11.
- The time period for prescriptions is ‘in the last 15 months’.

CHD10 - The percentage of patients with Coronary Heart Disease who are currently treated with a beta-blocker (unless a contraindication or side effects are recorded).
Range 40-60%
Points 7
- This indicator is unchanged from 2010-11.
- The time period for prescriptions is ‘in the last 6 months’.

CHD11 – The percentage of patients with a history of myocardial infarction (diagnosed after 1.4.03) who are currently treated with an ACE Inhibitor or angiotensin II antagonist. Removed – replaced by CHD14

CHD 14 - The percentage of patients with a history of myocardial infarction (from 1 April 2011) currently treated with an ACE inhibitor (or ARB if ACE intolerant), aspirin or an alternative anti-platelet therapy, beta-blocker and statin (unless a contraindication or side effects are recorded)
Range 40-80%
Points 10
- To meet this indicator patients need to have received all 4 types on medication in the last 6 months (or OTC code for aspirin in last 15 months and OTC code for statin in last 6 months), or have a combination of these plus exception codes for any they are not taking. The different time periods for OTC aspirin and statin have been raised as an issue.
- V20 added combination drug Hydrochlorothiazide + Olmesartan to ARB drug searches.

CHD12 - The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 September to 31 March.
Range 40-90%
Points 7
- Exception coding for this indicator remain the same as for 2010 – 11.
- Specific vaccinations for pandemic (H1N1) Influenza are not included for meeting this indicator.
Population CKD1 The practice can produce a register of patients aged 18 years and over with CKD. (US National Kidney Foundation: Stage 3-5 CKD)

Points 6
- For patients age 18 or over.
- NOTE the Contract guidance states that ‘This indicator set applies to people with stage three, four and five CKD (eGFR <60 mL/min/1.73m$^2$ for over 3 months).’ This implies that a patient should not be diagnosed with a specific stage of renal disease without at least 2 eGFR results over a 3 month period.

Laboratories in Scotland calculate estimated Glomerular filtration rate (eGFR) and add this to their standard results. From this practices will need to add the correct coding for the stage of renal disease where appropriate. The coding is based on the International classification developed by the US National Kidney Foundation which describes 5 stages of chronic kidney disease.

**Classification of CRD - From US National Kidney Foundation**

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
<th>GFR</th>
<th>Read Code</th>
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<td>Stage 1</td>
<td>Kidney Damage with normal or raised GFR</td>
<td>&gt;=90</td>
<td>1Z10.</td>
</tr>
<tr>
<td>Stage 2</td>
<td>Kidney Damage with mild decrease GFR</td>
<td>60 - 89</td>
<td>1Z11.</td>
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<tr>
<td>Stage 3</td>
<td>Moderate decrease in GFR</td>
<td>30 - 59</td>
<td>1Z12.</td>
</tr>
<tr>
<td>Stage 4</td>
<td>Severe decrease in GFR</td>
<td>15 - 29</td>
<td>1Z13.</td>
</tr>
<tr>
<td>Stage 5</td>
<td>Kidney Failure</td>
<td>&lt; 15 (or dialysis)</td>
<td>1Z14.</td>
</tr>
</tbody>
</table>

- The Consensus statement on management of early CKD, February 2007 by the Renal Organisation states:

We recommend sub-classifying CKD stage 3 into 2 groups, 3A and 3B:

- 3A defines a lower risk group with eGFR of 45-59.
- 3B defines a higher risk group with eGFR of 30-44.

In addition for each of the CKD Stages there are now codes defining ‘CKD without Proteinuria’ and ‘CKD with Proteinuria’. These have been added to the codes that count as ‘Proteinuria. If patient also has hypertension they will count for indicator CKD5. For Read codes click on link to SCIMP list of V20 Contract Read codes [http://www.scimp.scot.nhs.uk/coding_guidance.html](http://www.scimp.scot.nhs.uk/coding_guidance.html).
- Codes for Stages 1 and 2, if they are the most recent of any of the codes, will remove the patient from the register.
- There are overall exception codes available for patient unsuitable and informed dissent.
- CKD is included as a disease area in the Smoking 3 and 4 Indicators. CKD exception codes will not count for this. There are separate Smoking exception codes.

**Indicators**

**CKD2** ‘The percentage of patients on the CKD register whose notes have a record of blood pressure in the preceding 15 months.’
Range 40-90%
Points 6

**CKD3** ‘The percentage of patients on the CKD register in whom the last blood pressure reading, measured in the preceding 15 months, is 140/85 or less.’
Range 40-70%
Points 11
- these indicators are unchanged from 2010-11. The same exception codes exist for blood pressure procedure refused (applies to Indicators CKD2 and 3) and on maximal tolerated hypertensive treatment (applies to Indicator CKD3).

**CKD5** ‘The percentage of patients on the CKD register with hypertension and proteinuria who are treated with an angiotensin converting enzyme inhibitor (ACE-I) or angiotensin receptor blocker (ARB) (unless a contraindication or side effects are recorded)’
Range 40-80%
Points 9

The population for this = patients on the CKD register AND on the Hypertension register AND with a code for ‘Proteinuria’. The codes for Proteinuria differ from those specified in the Diabetes indicators – see SCIMP Contract Read codes for listing of codes.

- Prescriptions should have been prescribed within the last 6 months.
- V20 added combination drug Hydrochlorothiazide + Olmesartan to A11 drug searches.
- To exception code from this indicator an exception code for BOTH an ACE Inhibitor AND an A II receptor blocker needs to be entered within the appropriate time scale (some codes are permanent and some expire after 15 months).

**CKD 6** – The percentage of patients on the CKD register whose notes have a record of a urine albumin: creatinine ratio (ACR) or protein: creatinine ratio (PCR) test recorded in the previous 15 months.
Range 40-80%
Points 6

- Acceptable codes are:
  44ID. Urine protein/creatinine ratio
  46TC. Urine albumin:creatinine ratio
**COPD**

**Population– COPD14**—(Indicator renumbered, previously COPD1) The practice can produce a register of patients with COPD.

*Points 3*

NICE clinical guideline 101 has recommended a change to the diagnostic threshold for COPD. See [http://guidance.nice.org.uk/CG101](http://guidance.nice.org.uk/CG101) for further details. As this may lead to an increase in the recorded prevalence of COPD, this indicator has been renumbered from April 2011 in recognition of this.

It is now accepted that patients can have co-existing Asthma and COPD and therefore may be on both registers.

**Indicators**

- Patients with COPD are included in the indicators Smoking 3 and 4. The COPD exception codes do not apply and there are separate ‘Smoking’ exception codes that can be used.

**COPD15** – (Indicator renumbered, previously COPD12 + note date change) The percentage of all patients with COPD diagnosed after 1 April 2011 in whom the diagnosis has been confirmed by post bronchodilator spirometry Range 40-80%

*Points 5*

- The spirometry code requires entry within the time period of 3 months before to 12 months after the earliest COPD code.
- It is possible to exception code people from this specific indicator if spirometry is contra-indicated, not indicated or declined. These require re-entry every 15 months.
- V19 significant changes to codesets. 33H%, 33I%, 33J%, 66Ta - 66Yb all removed. V19 Now only 2 codes acceptable 8HRC. (Referral for spirometry) and the newly added code 745D4 (Post bronchodilator spirometry) Click on link for SCIMP Contract Read codes [http://www.scimp.scot.nhs.uk/coding_guidance.html](http://www.scimp.scot.nhs.uk/coding_guidance.html). Note that they are different from the spirometry codes used for the asthma population. Care will be needed in patients who have both conditions.
- V19 Spirometry exception codes - removed codes 8I2M. (Spirometry reversibility testing contraindicated) and 8I6d. (Spirometry reversibility testing not indicated)
-
COPD10 – The percentage of patients with COPD with a record of FEV1 in the preceding 15 months.
Range 40-70%
Points 7

- V20 New code added to FEV1 codes - 339O1 (Forced expired volume in one second/vital capacity ratio)

COPD 13 – The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the MRC dyspnoea score in the preceding 15 months.
Range 50-90%
Points 9

- Patients require both a COPD review code AND an MRC dyspnoea score code entered in the last 15 months to meet this indicator

<table>
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<td>4</td>
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- V20 New codes added to the COPD review codes
  66YB0 (Chronic obstructive pulmonary disease 3 monthly review)
  66YB1 (Chronic obstructive pulmonary disease 6 monthly review)

COPD8 – The percentage of patients with COPD who have had influenza immunisation in the preceding 1st September to 31st March.
Range 40-85%
Points 6

- Exception coding for this indicator remain the same as for 2010 – 11.
- Specific vaccinations for pandemic (H1N1) Influenza are not included for meeting this indicator.
PP1 – Note change to wording In those patients with a new diagnosis of hypertension (excluding those with pre-existing CHD, diabetes, stroke and/or TIA) recorded between the preceding 1 April to 31 March: the percentage of patients aged 30 to 74 years who have had a face to face cardiovascular risk assessment at the outset of diagnosis (within three months of the initial diagnosis) using an agreed risk assessment treatment tool.
Range 40-70%
Points 8

- Patients with codes for IHD, Diabetes, Stroke, TIA, CKD PVD or Familial hypercholesterolaemia are excluded from this population requiring CHD Risk assessment. See http://www.scimp.scot.nhs.uk/coding_guidance.html for list of codes for these disease areas.
- Patients newly diagnosed with hypertension age <30 or >=75 do not require CVD Risk assessment but do still require lifestyle advice.
- Risk assessment codes require entry within the time scale of 3 months before to 3 months after the new Hypertension diagnosis date.
- There are overall exception codes available for patient unsuitable and informed dissent. For Indicator PP2 these will require re-entry every 15 months.
- There are also 2 codes that exception code patients specifically from requiring risk assessment
  8IAK. (Cardiovascular disease high risk review declined)
  9Oh9. (Cardiovascular disease risk assessment declined)

PP2 – The percentage of people diagnosed with hypertension (diagnosed after 1 April 2009) who are given lifestyle advice in the preceding 15 months for: increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet.
Range 40-70%
Points 5

- There are two Read codes, 67H.. (Lifestyle counselling) or 67H8. (Lifestyle advice regarding hypertension) that counts for this indicator. However the BMA QOF Guidance states:-
  ‘Verification – PCOs may randomly select a number of case records of patients in which this advice has been recorded as taking place to confirm that the four key issues are recorded as having been addressed, if applicable.’

It may therefore be sensible to add addition information either as text or specific Read codes to show types of counselling given.
DEMENTIA

Population DEM1 ‘The practice can produce a register of patients diagnosed with dementia.’

Points 5
- There are overall exception codes available for patient unsuitable and informed dissent.

Indicators

DEM2 – ‘The percentage of patients diagnosed with dementia whose care has been reviewed in the preceding 15 months.’

Range 25-60%

Points 15
- Details of what should be included in a review are listed in the QOF guidance (see links to BMA and NHS Employers websites on page 1). A review of carers needs is included within this.
- The only acceptable code for review is 6AB. (Dementia annual review).

DEM 3 (New indicator)- The percentage of patients with a new diagnosis of dementia (from 1 April 2011) with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded 6 months before or after entering on to the register

Range 40-80%

Points 6
- Codes specified as on SCIMP spreadsheet. Care will be needed to ensure that imported lab results are codes with appropriate codes to meet this dataset.
- Codes for blood tests require entry within time period 6 months before to 6 months after the first diagnosis date
Population
- These are different populations for the 3 indicators – see below.
- There are overall exception codes available for patient unsuitable and informed dissent, these apply to all indicators. It should be noted that Diabetes or CHD exception codes do not apply to DEP1.

Indicators

DEP1 – ‘The percentage of patients on the diabetes register and/or the CHD register for whom case finding for depression has been undertaken on one occasion during the preceding 15 months using two standard screening questions.’
Range 40-90%
Points 6
- The population is all patients who are currently on either the Diabetes register or the Coronary Heart Disease register. From this group patients who have been diagnosed with depression in the last 15 months and have not been screened for depression with the 2 questions, will be excluded from the population. Patients who do have the screening questions and are then subsequently diagnosed with depression will remain in the population.
- Diabetes or CHD exception codes do not count. There are separate ‘Depression’ exception codes that can be used.
- The two standard screening questions are:-
  1. During the last month, have you been bothered by feeling down, depressed or hopeless?
  2. During the last month, have you often been bothered by having little interest or pleasure in doing things?

These two questions may be best integrated as part of the CHD or Diabetes annual review and then coded accordingly. A ‘yes’ to either question is considered a positive test and they should then be assessed for further symptoms of depression. For 2008-09 the guidance has been modified to specify that these questions should be asked as part of a consultation and should not be posted to patients.

DEP 4 (replaced the previous DEP2 with different wording) – In those patients with a new diagnosis of depression, recorded between the preceding 1 April to 31 March, the percentage of patients who have had an assessment of severity at the time of diagnosis using an assessment tool validated for use in primary care.
Range 40-90%
Points 17
- The search looks for the latest, first or new entry of a Depression code within the time period. Care may be needed in the dating of codes if you commonly record diagnosis read codes at each patient encounter. Your software system will advise on the correct way to indicate a new diagnosis.
- A Depression resolved code is available which will remove the patient from the population if dated after the most recent depression code. At present this code should be used with caution as it will have the effect of reducing your Depression population and possibly your payments.
- Any entry of one of the Depression codes will put the patient into the population. **Entry of the assessment score needs to be entered within 28 days after the latest depression code date**
- The search looks back 15 months from the reference date, therefore although the indicator states ‘the previous 1st April to 31st March, patients diagnosed from the previous 1st January may be included. If they had a 1st assessment prior to 1st April they will be excluded.
- Applies only to patients age 18 or over and does not include post-natal depression. Care should be taken as code E204. (Neurotic depression reactive type) which is a commonly used code, is not included for the Contract as it has a synonym term for post-natal depression.
- Care is also needed with codes for depression that indicate psychosis as they will also include the patient in the Mental Health register.

The three assessment tools to choose from are:
1. Patient Health Questionnaire (PHQ9) – can be downloaded free of charge from [www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/questionnaire/](http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/questionnaire/)
2. The Beck Depression Inventory 2nd edition (BDI-II) - can be ordered from [http://harcourtassessment.com/cgi-bin/MsmGo.exe?grab_id=112&page_id=9707008&query=beck%2A&hiword=besk%2A+](http://harcourtassessment.com/cgi-bin/MsmGo.exe?grab_id=112&page_id=9707008&query=beck%2A&hiword=besk%2A+)
3. The Hospital Anxiety and Depression Scale(HADS) – can be ordered from [www.nfer-nelson.co.uk/catalogue/catalogue_detail.asp?catid=98&id=1125](http://www.nfer-nelson.co.uk/catalogue/catalogue_detail.asp?catid=98&id=1125)

**DEP 5** Replaced the previous DEP3 – In those patients with a new diagnosis of depression and assessment of severity recorded between the preceding 1 April to 31 March, the percentage of patients who have had a further assessment of severity **4-12 weeks (inclusive)** after the initial recording of the assessment of severity. Both assessments should be completed using an assessment tool validated for use in primary care. (as for Dep4).

**Range** 40-80%

**Points** 8

- Second assessment requires entry within **4 – 12 weeks** after the first assessment. Note this is not after the diagnosis date. Previously was 5 – 12 weeks.
- The same Assessment Read codes are used for the first and second assessments
- Patients will only meet this indicator if they have both the first assessment within 28 days of diagnosis AND the second assessment 4-12 weeks after the first.
- The search looks back 68 weeks from the reference date, therefore although the indicator states ‘the previous 1st April to 31st March, patients diagnosed before 1st April may be included. If they had a 2nd assessment prior to 1st April they will be excluded.
DIABETES

Population DM19 – The practice can produce a register of all patients age 17 years and over with Diabetes Mellitus, which specifies whether the patient has Type 1 or Type 2 diabetes.

Points 6
- The codes for the Diabetes population are only those with a preferred term specifying either Type 1 or Type 2. Note the synonyms for codes C108. and C109. are not included, only codes in the C10E. (Type 1 diabetes mellitus) and C10F. (Type 2 diabetes mellitus) hierarchies count.
- It is possible to remove patients from the population by using one of the Diabetes resolved codes. This is required to be dated after the most recent Diabetes Read code.

Indicators

- Patients with Diabetes are included in the indicators Smoking 3 and 4. The Diabetes exception codes do not apply and there are separate ‘Smoking’ exception codes that can be used.
- Although not an indicator within Diabetes, patients with diabetes are required to be assessed for possible depression using the 2 standard questions (see Depression). For assessment of depression the Diabetes exception codes do not apply and there are separate ‘Depression’ exception codes that can be used.

DM2. The percentage of patients with diabetes whose notes record BMI in the preceding 15 months.
Range 40-90%
Points 3

DM5. The percentage of patients with diabetes who have a record of HbA1c or equivalent in the previous 15 months. Removed V19

DM 26: (Replacing previous DM23 – HbA1c <7) The percentage of patients with diabetes in whom the last IFCC-HbA1c is 59 mmol/mol (equivalent to HbA1c of 7.5% in DCCT values) or less (or equivalent test/reference range depending on local laboratory) in the preceding 15 months.
Range 40-50%
Points 17

DM 27: (Replacing previous DM24 – HbA1c <8) The percentage of patients with diabetes in whom the last IFCC-HbA1c is 64 mmol/mol (equivalent to HbA1c of 8% in DCCT values) or less (or equivalent test/reference range depending on local laboratory) in the preceding 15 months
Range 40-70%
Points 8
**DM 28.** (Replaced previous DM25) The percentage of patients with diabetes in whom the last IFCC-HbA1c is 75 mmol/mol (equivalent to HbA1c of 9% in DCCT values) or less (or equivalent test/reference range depending on local laboratory) in the preceding 15 months.

*Range 40-90%*

*Points 10*

- It is possible to specifically exception code for these indicators, for patients on maximum tolerated diabetes treatment.
- For 2011-12, searches will accept either HbA1c results (as a percentage) or the new IFCC HbA1c (as mmol/mol) results. For reference:

  - HbA1c (%) IFCC HbA1c (mmol/mol)
  - <=7.5 <=59
  - <=8 <=64
  - <=9 <=75

**DM21.** The percentage of patients with diabetes who have a record of retinal screening in the preceding 15 months.

*Range 40-90%*

*Points 5*

- Patients can be specifically exception coded from this indicator if retinal screening is not indicated, unsuitable or refused. These exclusion codes require review and re-entry if appropriate, every 15 months.

**DM29: The percentage of patients with diabetes with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 15 months.

*Range 40-90%*

*Points 4*

- V19 – new exception codes added for amputations of leg. Note specific codes required and need to have two codes for right and left amputations to except from this indicator

**DM10.** The percentage of patients with diabetes with a record of neuropathy testing in the preceding 15 months.

*Range 40-90%*

*Points 3*

- Patients can be specifically exception coded from these indicators if foot examination or neuropathy testing is not indicated or declined. These codes require review and re-entry if appropriate, every 15 months.
- V19 – care is needed in the exception codes used as need to be specific for Diabetic foot examination or neuropathy testing not indicated or refused.
- V19 – new exception codes added for amputations of leg. Note specific codes required and need to have two codes for right and left amputations to except from this indicator

**DM11.** The percentage of patients with diabetes who have a record of the blood pressure in the preceding 15 months. – V19 Removed
DM12. The percentage of patients with diabetes in whom the last blood pressure is 145/85 or less. V19 Replaced by DM30 and DM31 below

DM 30. The percentage of patients with diabetes in whom the last blood pressure is 150/90 or less.
Range 40-71%
Points 8

DM 31. The percentage of patients with diabetes in whom the last blood pressure is 140/80 or less.
Range 40-60%
Points 10

DM 13: The percentage of patients with diabetes who have a record of microalbuminur­­inuria testing in the preceding 15 months (exception reporting for patients with proteinuria).
Range 40-90%
Points 3

DM 22: The percentage of patients with diabetes who have a record of estimated glomerular filtration rate (eGFR) or serum creatine­nine testing in the preceding 15 months.
Range 40-90%
Points 3
- estimated Glomerular filtration rate (codes 451E or 451F) was added in 2006-07, as an alternative to creatinine testing. Creatinine testing on its own is still sufficient to meet this indicator.
- Codes remain unchanged from 2010-11

DM15. The percentage of patients with diabetes with a diagnosis of proteinuria or micro-proteinuria who are treated with ACE inhibitors (or A2 antagonists).
Range 40-80%
Points 3
- The time period for prescriptions is ‘in the last 6 months’.
- To exception code from this indicator an exception code for BOTH an ACE Inhibitor AND an A II receptor blocker needs to be entered within the appropriate time scale (some codes are permanent and some expire after 15 months).

DM16. The percentage of patients with diabetes who have a record of total cholesterol in the previous 15 months. V19 Removed

DM 17: The percentage of patients with diabetes whose last measured total cholesterol within the preceding 15 months is 5 mmol/l or less.
Range 40-70%
Points 6

DM18. The percentage of patients with diabetes who have had influenza immunisation in the preceding 1st September to 31st March.
Range 40-85%
Points 3
**EPILEPSY**

**Population – EPILEPSY 5** (Previously Epilepsy 1) The practice can produce a register of patients aged 18 years and over receiving drug treatment for epilepsy.

*Points 1*
- Patients require an appropriate Read Code and an epilepsy medication prescription within the last 6 months.
- It is possible to remove patients from the population by using one of the Epilepsy resolved codes. This is required to be dated after the most recent Epilepsy Read code.
- There are overall exception codes available for patient unsuitable and informed dissent. These require re-entry every 15 months.

**Indicators**

**EPILEPSY 6:** The percentage of patients aged 18 years and over on drug treatment for epilepsy who have a record of seizure frequency in the preceding 15 months.

*Range 40-90%*

*Points 4*

**EPILEPSY 7** – The percentage of patients aged 18 years and over on drug treatment for epilepsy who have a record of medication review involving the patient or carer in the previous 15 months. Removed

**EPILEPSY 8:** The percentage of patients aged 18 years and over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the preceding 15 months.

*Range 40-70%*

*Points 6*
- this indicator is the same as 2007-08 apart from the qualifying age range.
- Patients can be specifically excluded from this indicator if they are considered to be on maximum anticonvulsant therapy.

**EPILEPSY 9:** The percentage of women under the age of 55 years who are taking antiepileptic drugs who have a record of information and counselling about contraception, conception and pregnancy in the preceding 15 months. New Indicator

*Range 40-90%*

*Points 3*
- Applies to women age under 55
- Patients require a separate code for each of the 3 types of counselling, entered within the last 15 months, to meet the new Epilepsy9 indicator. It is not necessary for these all to be entered on the same date.
- Patients with a code for sterilisation or hysterectomy are permanently excluded from this indicator
- There are separate codes to exclude from each of the 3 types of counselling. To exclude a patient as refused or not appropriate the patient requires either an exclusion codes or a code to meet the criteria, for each of the 3 types of counselling.
HEART FAILURE

Population HF1 The practice can produce a register of patients with Heart Failure
Points 4
- There are overall exception codes available for patient unsuitable and informed dissent. These require re-entry every 15 months. It is important to ensure that it is the Heart Failure exception codes (9hH%) that are used rather than the LVD exception codes. The latter were removed from the specifications in Version 10.

Indicators

- Patients with Heart Failure are included in the indicators Smoking 3 and 4. The Heart Failure exception codes do not apply and there are separate ‘Smoking’ exception codes that can be used.

HF 2: The percentage of patients with a diagnosis of heart failure (diagnosed after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment
Range 40-90%
Points 6
- The code for echocardiogram or referral needs to be recorded within the timescale of 3 months before to 12 months after the earliest Heart Failure code (if after 1.4.06).
- There are specific codes to exclude patients from this indicator (Echo declined or Angiocardiography declined)

HF3: The percentage of patients with a current diagnosis of heart failure due to Left Ventricular Dysfunction (LVD) who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker (ARB), who can tolerate therapy and for whom there is no contraindication
Range 40-80%
Points 10
- The population for this indicator is a subgroup of the Heart Failure population. They require a specific code for Left Ventricular dysfunction.
- Prescriptions need to have been prescribed within the last 6 months.
- To exclude a patient they require individual exclusion codes for both ACE inhibitor AND Angiotensin Receptor Blocker.
HF4: The percentage of patients with a current diagnosis of heart failure due to LVD who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker (ARB), who are additionally treated with a beta-blocker licensed for heart failure, or recorded as intolerant to or having a contraindication to beta-blockers. Range 40-60%
Points 9
- Patients not on an ACE or ARB Receptor blocker are not included in this population.
- Prescriptions need to have been prescribed within the last 6 months.
- Licensed beta-blockers are carvedilol, bisoprolol and nebivolol. However patients who are on an unlicensed beta blocker prescribed anytime after 6 months before the Heart Failure diagnosis date are excluded from the population as it may not be appropriate to change them to a licensed preparation.
**HYPERTENSION**

**Population BP1** – *The practice can produce a register of patients with established hypertension.*

*Points 6*

- It is possible to remove patients from the population by using one of the Hypertension resolved codes. This is required to be dated after the most recent Hypertension diagnosis Read code.
- There are overall exception codes available for patient unsuitable and informed dissent. These require re-entry every 15 months.

**Indicators**

- Patients with Hypertension are included in the indicators Smoking 3 and 4. The Hypertension exception codes do not apply and there are separate ‘Smoking’ exception codes that can be used.

**BP 4:**  *The percentage of patients with hypertension in whom there is a record of the blood pressure in the preceding 9 months.*

*Range 40-90%*

*Points 16*

**BP 5:**  *The percentage of patients with hypertension in whom the last blood pressure (measured in the preceding 9 months) is 150/90 or less.*

*Range 40-70%*

*Points 57*
**HYPOTHYROID**

**Population Thyroid 1** – *The practice can produce a register of patients with hypothyroidism*

*Points 1*

- Unchanged from 2010-11

**Indicators**

**THYROID 2:** *The percentage of patients with hypothyroidism with thyroid function tests recorded in the preceding 15 months.*

*Range 40-90%*

*Points 6*

- Unchanged from 2010-11
Population – LD 1: The practice can produce a register of patients aged 18 years and over with learning disabilities.

Points 4
- this applies to patients age 18 years or over.

Indicators

LD 2: The percentage of patients on the learning disability register with Down’s Syndrome aged 18 years and over who have a record of blood TSH in the preceding 15 months (excluding those who are on the thyroid disease register)

Range 40-70%

Points 3

- A previous diagnosis of hypothyroidism + on medication will exclude patient from indicator LD2 unless the hypothyroid diagnosis has been made within the last 15 months. Prescription of levothyroxine requires to be in the previous 6 months
- There are specific exclusion codes for patient not suitable and patient refused.
MENTAL HEALTH

Population- MH8

The practice can produce a register of people with schizophrenia, bipolar affective disorder and other psychosis.

Points 4

Patients are included in this population if they have either:

1. one of the defined codes for schizophrenia, bipolar affective disorder or other psychosis.

Or

2. they have received a prescription for Lithium in the last 6 months and have no subsequent ‘Stopped Lithium’ code.

Note - Patients who qualify only through group 2 above (on lithium) are not included in indicators MH11, MH12, MH13, MH14, MH15, MH16 or MH6.

- The concept that a patient may opt out of review (ie. Say they do not wish to be on the register) has been removed (since 2005-06). They may still be exception coded as for the other QOF disease areas.

- New codes have been added to allow coding of Mental Health problems in remission. These will permanently remove the patient from the MH register unless a subsequent MH code is added to their record.

Indicators

- Schizophrenia, Bipolar disorder and other psychosis are now included as disease areas in the Smoking 3 and 4 Indicators. Mental Health exception codes will not count for this. There are separate Smoking exception codes.

MH9 — The % of patients with schizophrenia and bipolar disorder and other psychosis with a review recorded in the previous 15 months. In the review there is evidence that the patient has participated in routine health promotion and prevention advice appropriate to their age and health status. Removed and replace by indicators MH11, MH12, MH13, MH14, MH15, MH16.

- There is no longer a requirement to enter a Read code for Mental Health Review

MH11: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months

Range 40-90%

Points 4

- Patients can be coded as having refused Alcohol consumption screening using codes :-

8IA7. Alcohol consumption screening test declined

8IAt. Extended intervention for excessive alcohol consumption declined

These codes require re-entry every 15 months

MH12: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 15 months.

Range 40-90%

Points 4

- This uses the same Read codes for BMI as for the Diabetes indicator.
MH13: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 15 months.
Range 40-90%
Points 4
- Patient can be codes as refusing blood pressure monitoring using code:- 8I3Y. Blood pressure procedure refused
  This code requires re-entry every 15 months

MH14. The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol:hd1 ratio in the preceding 15 months
Range 40-80%
Points 5

MH15: The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose in the preceding 15 months.
Range 40-80%
Points 5
- Patients with Diabetes diagnosed more that 12 months ago will be excluded from this indicator unless they have a subsequent ‘Diabetes resolved’ code.

MH16: The percentage of patients (aged from 25 to 64 in England and Northern Ireland, from 20 to 60 in Scotland and from 20 to 64 in Wales) with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years.
Range 40-80%
Points 5
- Patients coded as having had a hysterectomy will be permanently excluded from this indicator.
- Patients can also be excluded from this indicator using codes
  6853. Ca cervix screen - not wanted
  685L. Cervical smear refused
  816K. Cervical smear not indicated
  9O8Q. Cerv.smear disclaimer received
  These codes require re-entry every 5 years

MH17: The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months. Replaces indicator MH4 which required tests in the previous 15 months
Range 40-90%
Points 1
MH18: The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months. Replaces indicator MH5 which required tests in the previous 6 months.

Range 40-90%
Points 2

- Patients who have received a lithium prescription in the last 4 months are included in these indicators. The use of a subsequent ‘Stopped Lithium’ code may not remove the patient from these indicators if they meet the other group for inclusion in the Mental Health population (i.e. have a diagnostic code).

MH10 – The percentage of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate. (renumbered – used to be MH6)

Range 25-50%
Points 6

- Only patients qualifying under 1 above are included for this indicator.
- The Mental Health care plan codes require to be entered any time after the earliest Mental Health diagnosis code.
- There is new guidance information regarding what should be covered in a care plan see page 96 of QOF guidance documentation:

MH7 – The percentage of patients with Schizophrenia, bipolar affective disorder and other psychoses who do not attend the practice for their annual review who are identified and followed up by practice team within 14 days of non-attendance. Removed in V19
**OBESITY**

**Population - OB1:** The practice can produce a register of patients aged 16 years and over with a BMI greater than or equal to 30 in the preceding 15 months

Points 8

- It is the latest code that counts for the population. The guidance is unclear how a patient may be removed from the population if they lose weight and are coded as BMI below 30
- Applies to patients age 16 years or over.
- Guidance states that this is a prospective register of patients that have had their BMI measured as part of routine care.
Population – PC 3: The practice has a complete register available of all patients in need of palliative care/support irrespective of age.

Points 3
- From 2008 this applies to all patients irrespective of age (previously was only those age 18 years or over).
- This indicator applies to patients with an appropriate Palliative Care code dated after 1.4.08 (previously was after 1.4.06).

Indicators

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

Points 3
- There is no coding or search for this. Results will be based on ‘web-based’ reporting. The contract guidance states that ‘The practice should submit written evidence to the PCO describing the system for initiating and recording meetings.'
There are 3 different topics for which computer searches are defined. There are for Blood Pressure recording, Clinical Summaries and Smoking Status. Ethnicity has been removed for 2011-12

**Blood Pressure**

**Records 11:** The blood pressure of patients aged 45 years and over is recorded in the preceding 5 years for at least 65% of patients.

*Points 10*

**Records 17:** The blood pressure of patients aged 45 years and over is recorded in the preceding 5 years for at least 80% of patients.

*Points 5*

- The codes and searches are the same as for 2010 – 11

**Summaries**

**Records 15:** The practice has up-to-date clinical summaries in at least 60% of patient records

*Points 25*

**Records 18:** The practice has up-to-date clinical summaries in at least 80% of patient records

*Points 8*

**Records 20:** The practice has up-to-date clinical summaries in at least 70% of patient records

*Points 12*

- These are new searches introduced from 2006 – 07. Previously an audit of 50 patient notes was required as evidence.
- The introduction of these searches have been recognised as a problem in Scotland as summary codes have not routinely been used. A manual work around was devised for previous QOF years by NHS National Services Scotland, Practitioner Services Division (PSD). We are awaiting guidance as to whether this will continue for 2011 -12.

**Records 21—Ethnic origin is recorded for 100% of new registrations from 1.4.06.**

**Smoking**

**Records 23:** The percentage of patients aged 15 years and over whose notes record smoking status in the preceding 27 months

*Points 11*

**Payment stages 40-90%**

- There is no exception code available for this indicator.
- V14 – corrected previous searches so that smoking status is required in last 27 months. There are 2 specific differences to this:-
  1. If age over 25 never smoked recording is required only once after the age of 25
  2. For ex-smokers this can either be recorded in the last 27 months or recorded for 3 years in succession. Subsequent smoking status recording will negate these 3 years of ex-smoker recording.
SEXUAL HEALTH

Population (SH1) - The Practice can produce a register of women who have been prescribed any method of contraception at least once in the last year, or other appropriate interval e.g. last 5 years for an IUS

Points 4

- This applies to Contraception after 1.4.09
- Data will be picked up from prescriptions and also Read codes where entered. Click on link for SCIMP Contract Read code guidance and time intervals:
- There are overall exception codes available for patient unsuitable and informed dissent.
- V20 new codes added:
  - 61511 Insertion of T shaped 375 millimetres squared copper coated intrauterine contraceptive device
  - 61R.. Intrauterine system contraception
  - 9kr.. Subdermal etonogestrel implant insertion enhanced services administration

SH 2. The percentage of women prescribed an oral or patch contraceptive method who have also received information from the practice about long acting reversible methods of contraception in the preceding 15 months.

Range 40-90%

Points 3

- This applies to patients who have a prescription or Read code for oral or patch contraceptive in the last 15 months. If entering only read codes without electronic prescriptions, the Read codes will need re-entering each year.
- V20 new codes added
  - 679K2 Education for intrauterine system
  - 8CAw1 Verbal advice about long acting reversible contraception
  - 8CAw2 Written advice about long acting reversible contraception

Guidance stresses that both verbal and written information is required. If code 679K2 or 8CAw. (Advice about long acting reversible contraception) are used then it is assumed both have been given. If codes 8CAw1 or 8CAw2 are used the BOTH need to be entered to meet this indicator.
SH3 – The percentage of women prescribed emergency hormonal contraception at least once in the last year by the practice who have received information from the practice about long-acting reversible methods of contraception at the time of, or within one month of the prescription.

Range 40-90%

Points 3

- If there have been 2 or more issues of Emergency hormonal contraception for a patient, it is the most recent one that will count for this indicator.
- If issued within the last month the patient will be excluded if LARC advice not given. This is to allow for insufficient time being allowed to do this.
- V20 new codes added

  679K2 Education for intrauterine system
  8CAw1 Verbal advice about long acting reversible contraception
  8CAw2 Written advice about long acting reversible contraception

Guidance stresses that both verbal and written information is required. If code 679K2 or 8CAw. (Advice about long acting reversible contraception) are used then it is assumed both have been given. If codes 8CAw1 or 8CAw2 are used the BOTH need to be entered to meet this indicator.
**Population- Smoking 3:** 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.

Range 40-90%

Points 30

- All patients who are in one or more of the Contract populations for Coronary Heart Disease, Stroke or TIA, Hypertension, Diabetes, COPD, Asthma, CKD or Schizophrenia, Bipolar disorder or other Psychosis. An age limit of 20 is put on the Asthma patients. Those aged under 20 are covered in indicator Asthma3.

- Smoking status should be recorded after the first diagnosis date. If a patient has several of the population morbidities the smoking status should be recorded after the earliest recorded date of any of the morbidities. But also note changes below.

1. If age over 25 never smoked recording is required only once after the age of 25 and after the earliest date of diagnosis of relevant disease areas.

2. For ex-smokers this can either be recorded in the last 15 months or recorded for 3 years in succession. Subsequent smoking status recording will negate these 3 years of ex-smoker recording.

**Indicators**

**Smoking 4:** 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 who smoke whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered within the preceding 15 months.

Range 40-90%

Points 30

The population is patients whose latest code is for a ‘current smoker’. This can have been recorded at any time (i.e. not limited to those entered in the last 15 months).
**Population- Stroke** The practice can produce a register of patients with Stroke or TIA.

*Points 2*
- V20 excluded code G669. (Cerebral palsy, not congenital or infantile, acute) from Stroke and TIA diagnosis codes

**Indicators**

- Patients with Stroke or TIA are included in the indicators Smoking 3 and 4. The Stroke exception codes do not apply and there are separate ‘Smoking’ exception codes that can be used.

**STROKE 13** – The percentage of new patients with a stroke or TIA who have been referred for further investigation.

*Range 40-80%*

*Points 2*
- For patients who present with a new stroke or TIA code from 1.4.08.
- The code for scan or further referral should be dated within 3 months before to 1 month after the new stroke or TIA date (previously was 12 months after the diagnosis date).

**STROKE 5** — The percentage of patients with TIA or Stroke, who have a record of blood pressure in the notes in the preceding 15 months. V19 removed

**STROKE 6**: The percentage of patients with a history of TIA or stroke, in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 or less.

*Range 40-71%*

*Points 5*

**STROKE 7**: The percentage of patients with TIA or stroke, who have a record of total cholesterol in the preceding 15 months.

*Range 40-90%*

*Points 2*

**STROKE 8**: The percentage of patients with TIA or stroke, whose last measured total cholesterol (measured in the preceding 15 months) is 5 mmol/l or less.

*Range 40-60%*

*Points 5*
- These indicators remain the same as for 2010 – 11.
STROKE 12 – The percentage of patients with a Stroke shown to be non-haemorrhagic, or a history of TIA, who have a record that an anti-platelet agent (aspirin, clopidogrel, dipyridamole or a combination), or an anti-coagulant is being taken (unless a contraindication or side effects are recorded).

Range 40-90%

Points 4

- To exception report a patient from this indicator they will require an exception code for each of the 4 types of medication (salicylate, clopidogrel, anticoagulant and dipyridamole) within the required time scales.

- V20 added codes to the set for non-haemorrhagic stroke codes :-
  - G665. Pure motor lacunar syndrome
  - G666. Pure sensory lacunar syndrome
  - Gyu63 [X]Cerebrl infarctn due/unspcf occlusn or sten/cerebrl artrs
  - Gyu64 [X]Other cerebral infarction
  - Gyu65 [X]Occlusion and stenosis of other precerebral arteries
  - Gyu66 [X]Occlusion and stenosis of other cerebral arteries
  - Gyu6G [X]Cereb infarct due unsp occlus/stenos precerebr arteries

STROKE 10: The percentage of patients with TIA or stroke who have had influenza immunisation in the preceding 1 September to 31 March.

Range 40-85%

Points 2

- Exception coding for this indicator remain the same as for 2010 – 11.