Medicines Optimisation Comparators

Version: March 2017

Comparator Descriptions and Specifications

Contents

Introduction

The Medicines Optimisation dashboard is managed by the Medicines Optimisation Intelligence Group which is chaired by Bruce Warner, Deputy Chief Pharmacist, NHS England. This dashboard is part of the wider PPRS/Medicines Optimisation Programme, a joint programme of action by NHS England and the ABPI with the full support of Government through the Ministerial Industry Strategy Group.

Medicines Optimisation is about improving patient outcomes, quality and value from medicines use, guided by the principles of medicines optimisation, and to create a clinical pull to accelerate the optimal use of innovative, clinical and cost effective medicines which maximises the benefits of the PPRS Agreement.

This dashboard brings together a range of data relating to variation in medicines use and prescribing to inform the strategic medicines optimisation plans of CCGs and Trusts. It helps support NHS organisations in highlighting variation and facilitates discussion on how they compare with others across a range of comparators. It is not intended as a performance measurement tool and there are no targets.

Further information regarding medicines optimisation can be found on the NHS England website https://www.england.nhs.uk/?s=Medicines+Optimisation&search=

This document provides descriptions and specifications for the March 2017 Medicines Optimisation dashboard. Also included are details of withdrawn comparators as well as additions and changes to the previous comparators published November 2016.

Practice level data is refreshed monthly within the NHSBSA Information Services Portal https://apps.nhsbsa.nhs.uk/infosystems/welcome Further work will be progressed to make accessibility to practice level data easier.

Reporting Level

- CCG comparators show data at CCG level (aggregated to NHS England Area, Local Office, AHSN, STP, Similar 10 CCGs (InstantAtlas only), CCG demographic clusters, Region and England level)
- Hospital Trust comparators show data at Hospital Trust level (aggregated to Area, AHSN, STP, Trust cluster and England level) except % of Infliximab biosimilars uptake and CQC In-patient Survey (2015) Q60 to Q63 which are not aggregated
- Area, AHSN, Region, STP, Local Office, CCG Cluster and Trust cluster comparisons are shown in the excel version for both the CCG and Hospital Trust dashboard except for those comparators that are not aggregated as above

NHSBSA Data: Data quality assurance

NHS Prescription Services have their own internal quality process to assure the data they provide matches what was originally submitted as part of the prescription processing activity. Some processes are complex and manual therefore there may be random inaccuracies in capturing prescription information which are then reflected in the data but checks are in place to reduce the chance of issues occurring. The processes operate to a number of key performance indicators, one of which is the percentage Prescription Information Accuracy, the target being 99.0% and as at November 2016 the accuracy level achieved over the latest 12 month rolling period was 99.53%.

Changes to comparators for March 2017

The following table lists those comparators that have changed or had data refreshed since the November 2016 published version of the Medicines Optimisation dashboard.

Comparator Name: CCG	**Comments**
Antibacterial items per STAR PU	Yearly data now available for October 2015 – September 2016 and January 2016 – December 2016
Co-amoxiclav, Cephalosporins and Quinolones % items	Yearly data now available for October 2015 – September 2016 and January 2016 – December 2016
% EPS items	Quarterly data now available up to December 2016
% of Practices enabled for EPS	Data now available as at end of September 2016 and December 2016
% of Practices submitting EPS	Quarterly data now available up to December 2016
% of Repeat Dispensing	Yearly data now available for October 2015 – September 2016 and January 2016 – December 2016
% of EPS Repeat Dispensing	Yearly data now available for October 2015 – September 2016 and January 2016 – December 2016
% of Pharmacies conducting MUR	Yearly data now available for October 2015 – September 2016 and January 2016 – December 2016
Number of MUR per 1,000 dispensed items	Yearly data now available for October 2015 – September 2016 and January 2016 – December 2016
% of Pharmacies conducting NMS	Yearly data now available for October 2015 – September 2016 and January 2016 – December 2016
Number of NMS per 1,000 dispensed items	Yearly data now available for October 2015 – September 2016 and January 2016 – December 2016
NSAIDS: Ibuprofen & Naproxen % items	Quarterly data now available up to December 2016
Oral Anticoagulants % items	Quarterly data now available up to December 2016
Emergency Diabetes Admissions	Yearly data now available for July 2015 – June 2016
Antidepressants (selected): ADQ/STAR PU (ADQ based)	Quarterly data now available up to December 2016
Antidepressants: First choice % items (2015)	Quarterly data now available up to December 2016
Hypnotics: ADQ/STAR PU (ADQ based)	Quarterly data now available up to December 2016
Summary Care Records Availability	Data now available as of 10 February 2017
Emergency Asthma Admissions	Yearly data now available for July 2015 – June 2016
Emergency COPD Admissions	Yearly data now available for July 2015 – June 2016
Comparator Name: Hospital Trust	**Comments**
Biosimilar: % of Infliximab biosimilars uptake	The data included in the dashboard is now represented as 'The percentage of defined daily doses for the biosimilar versions of infliximab' and is extracted from the NHS Improvement Model Hospital Dashboard – Pharmacy and Medicines compartment. The data is sourced from the Rx-info Define system which is used by acute trusts. Data available is on a 13 month rolling basis.
NRLS % of harmful incidents	Formerly NRLS % of harmful events
NRLS reported medication incidents	Formerly NRLS reporting rate
Summary Care Records Utilisation	Data now available as at December 2016

Data has not been refreshed for the other remaining comparators.

Please note that the data for Medicines Reconciliation has not been refreshed on this occasion. The Safety Thermometer tool is now the responsibility of Salford NHS Foundation Trust; the NHSBSA are actively liaising with the Trust to facilitate data refreshes with the aim of including refreshed data in the next Medicines Optimisation dashboard planned for June 2017.

CCG Comparators

ANTIBIOTICS: Antibacterial items per STAR-PU

<table>
<tr><th colspan="3">Section 1: Introduction / Overview</th></tr>
<tr><td>1.1</td><td>Title</td><td>Antibacterial items per STAR PU</td></tr>
<tr><td>1.2</td><td>MO Theme</td><td>ANTIBIOTICS</td></tr>
<tr><td>1.3</td><td>Definition</td><td>Number of prescription items for antibacterial drugs (BNF 5.1) per oral antibacterial (BNF 5.1 sub-set) ITEM based STAR-PU</td></tr>
<tr><td>1.4</td><td>Reporting Level</td><td>CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs , CCG demographic cluster, Region and England)</td></tr>
<tr><td>1.5</td><td>Numerator</td><td>Total number of items for antibacterial drugs (BNF 5.1)

BNF Name BNF Code
Antibacterial Drugs 0501</td></tr>
<tr><td>1.6</td><td>Denominator</td><td>Total number of oral antibacterials (BNF 5.1 sub-set) ITEM based STAR-PU

Oral antibacterial (BNF 5.1 sub-set) ITEM based STAR PU (2013 weighting)

Age Band Male Female
0-4 0.8 0.8
5-14 0.3 0.4
15-24 0.3 0.6
25-34 0.2 0.6
35-44 0.3 0.6
45-54 0.3 0.6
55-64 0.4 0.7
65-74 0.7 1.0
75+ 1.0 1.3</td></tr>
<tr><td>1.7</td><td>Methodology</td><td>Numerator divided by the denominator

Represented as number of antibacterial items per STAR PU

ITEM based STAR PU values specific to the numerator are not available. Oral antibacterials (BNF 5.1 sub-set) ITEM based STAR PU values have been used as the denominator since items for non-oral antibacterials accounted for only 0.17% of all items for BNF 5.1 in 2014/15 (Source: ePACT).

STAR PUs are weightings devised by NHS Digital and the following link provides further information regarding Prescribing Measures

http://content.digital.nhs.uk/media/10027/Prescribing-measures-booklet/pdf/pres-meas-book-v7.pdf

NHSBSA update list size information throughout a financial quarter and these patient list sizes are only fully refreshed at the end of that financial quarter; therefore STAR PU values used in this comparator are based on the latest available complete patient list size.

(Other time periods and practice level data are available through NHSBSA Information Services Portal: https://apps.nhsbsa.nhs.uk/infosystems/welcome).
catalogued under the MOKTT reports</td></tr>
<tr><th colspan="3">Section 2: Rationale</th></tr>
<tr><td>2.1</td><td>Purpose</td><td>The purpose of the prescribing comparator is to support the evidence and messages included in the ‘Key therapeutic topics – Medicines management options for local implementation’ publication by highlighting variation in prescribing across organisations, with the aim of reducing variation and a movement of the mean in the appropriate direction over time. The comparator is intended to support organisations and prescribers in reviewing the appropriateness of current prescribing, revise prescribing where appropriate and monitor implementation.</td></tr>
<tr><td>2.2</td><td>Evidence and Policy Base</td><td>Antibiotic resistance poses a significant threat to public health, especially because antibiotics underpin routine medical practice. To help prevent the development of resistance it is important to only prescribe antibiotics when they are necessary, and not for self-limiting mild infections such as colds and most coughs, sinusitis, earache and sore throats.</td></tr>
</table>

		See the NICE website for the latest update of the Medicines and Prescribing Centre publication. http://www.nice.org.uk/mpc/keytherapeutictopics/keyTherapeuticTopics.jsp This metric is taken from the Medicines Optimisation Key Therapeutic Topics (MO KTT) Comparators 2015/16 developed by NHS Digital. http://content.digital.nhs.uk/media/18422/Descriptions-and-Specifications-201516/pdf/Descriptions_and_Specifications_2015_16.pdf
Section 3: Data		
3.1	**Data source**	NHS Business Services Authority
3.2	**Data owner & contact details**	nhsbsa.help@nhs.net
3.3	**Time Frame**	Refreshed quarterly with 12 months accumulated data Data available from January 2014
3.4	**Data quality assurance**	Please see data quality assurance statement pertaining to NHSBSA accuracy NHSBSA Data: Data quality assurance

ANTIBIOTICS: Co-amoxiclav, Cephalosporins and Quinolones % items

Section 1: Introduction / Overview		
1.1	**Title**	Co-amoxiclav, Cephalosporins and Quinolones % items
1.2	**MO Theme**	ANTIBIOTICS
1.3	**Definition**	Number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (sub-set of BNF 5.1)
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Number of prescription items for co-amoxiclav, cephalosporins and quinolones **BNF Name** — **BNF Code** Co-amoxiclav — 0501013K0 Cephalosporins — 0501021 Quinolones — 050112
1.6	**Denominator**	Number of prescription items for BNF 5.1.1; 5.1.2.1; 5.1.3; 5.1.5; 5.1.8; 5.1.11; 5.1.12; 5.1.13 **BNF Name** — **BNF Code** Cephalosporins — 0501021 Macrolides — 050105 Metronidazole, Tinidazole & Ornidazole — 050111 Penicillins — 050101 Quinolones — 050112 Sulphonamides & Trimethoprim — 050108 Tetracyclines — 050103 Urinary-Tract Infections — 050113
1.7	**Methodology**	Numerator divided by denominator Represented as percentage of items for co-amoxiclav, cephalosporins and quinolones The denominator attempts to exclude antibiotics that do not provide a suitable alternative to co-amoxiclav, cephalosporins or quinolones and/or are specialist antibiotics i.e. (Other time periods and practice level data are available through NHSBSA Information Services Portal: https://apps.nhsbsa.nhs.uk/infosystems/welcome) catalogued under the MOKTT reports
Section 2: Rationale		
2.1	**Purpose**	The purpose of the prescribing comparator is to support the evidence and messages included in the 'Key therapeutic topics – Medicines management options for local implementation' publication by highlighting variation in prescribing across organisations, with the aim of reducing variation and a movement of the mean in the appropriate direction over time. The comparator is intended to support organisations and prescribers in reviewing the appropriateness of current prescribing, revise prescribing where appropriate and monitor implementation.
2.2	**Evidence and Policy Base**	Antibiotic resistance poses a significant threat to public health, especially because antibiotics underpin routine medical practice. To help prevent the development of resistance it is important to only prescribe antibiotics when they are necessary, and not for self-limiting mild infections such as colds and most coughs, sinusitis, earache and sore throats. HPA guidance recommends that simple generic antibiotics should be used if possible when antibiotics are necessary. Broad-spectrum antibiotics (for example, co-amoxiclav, quinolones and cephalosporins) should be avoided when narrow-spectrum antibiotics remain effective because they increase the risk of methicillin-resistant Staphylococcus aureus (MRSA), Clostridium difficile and resistant urinary tract infections. See the NICE website for the latest update of the Medicines and Prescribing Centre publication http://www.nice.org.uk/mpc/keytherapeutictopics/keyTherapeuticTopics.jsp This comparator is taken from the Medicines Optimisation Key Therapeutic Topics (MO KTT) Comparators 2015/16 developed by NHS Digital http://content.digital.nhs.uk/media/18422/Descriptions-and-Specifications-201516/pdf/Descriptions_and_Specifications_2015_16.pdf
Section 3: Data		

3.1	**Data source**	NHS Business Services Authority
3.2	**Data owner & contact details**	nhsbsa.help@nhs.net
3.3	**Time Frame**	Refreshed quarterly with 12 months accumulated data Data available from January 2014
3.4	**Data quality assurance**	Please see data quality assurance statement pertaining to NHSBSA accuracy NHSBSA Data: Data quality assurance

COMMUNITY SUPPORT: % EPS items

Section 1: Introduction / Overview		
1.1	**Title**	% EPS items
1.2	**MO Theme**	COMMUNITY SUPPORT
1.3	**Definition**	Percentage of all items supplied via electronic prescriptions service (EPS)
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Number of items prescribed and dispensed via EPS during the reporting period
1.6	**Denominator**	The total number of items prescribed and dispensed during the reporting period
1.7	**Methodology**	Numerator divided by denominator Represented as percentage of all items supplied electronically (Other time periods and practice level data are available through NHSBSA Information Services Portal: https://apps.nhsbsa.nhs.uk/infosystems/welcome) catalogued under the Prescribing Monitoring reports
Section 2: Rationale		
2.1	**Purpose**	Almost all community pharmacies are Electronic Prescription Service (EPS) enabled but many GP practices are not. This comparator aims to allow a CCG to explore how EPS could be deployed locally to derive the greatest benefit for patients and efficient prescription services.
2.2	**Evidence and Policy Base**	EPS enables prescribers such as GPs and practice nurses to send prescriptions electronically to a dispenser (such as a pharmacy) of the patient's choice. The prescription is then sent on to NHS Business Services Authority for payment. This makes the prescribing and dispensing process more efficient and convenient for patients and staff.
Section 3: Data		
3.1	**Data source**	NHS Business Services Authority
3.2	**Data owner & contact details**	nhsbsa.help@nhs.net
3.3	**Time Frame**	Refreshed quarterly with quarterly data Data available from October 2014
3.4	**Data quality assurance**	Please see data quality assurance statement pertaining to NHSBSA accuracy NHSBSA Data: Data quality assurance

COMMUNITY SUPPORT: % of Practices enabled for EPS

Section 1: Introduction / Overview		
1.1	**Title**	% of Practices enabled for EPS
1.2	**MO Theme**	COMMUNITY SUPPORT
1.3	**Definition**	Percentage of practices enabled for electronic prescriptions (EPS)
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Number of practices that have submitted at least one live prescription up to the end of the reporting period
1.6	**Denominator**	Number of practices at the end of the reporting period
1.7	**Methodology**	Numerator divided by denominator Represented as percentage of practices enabled for EPS A practice is determined as enabled when a claim has been received by the NHSBA Data is for GP practices active at any time during the reporting period
Section 2: Rationale		
2.1	**Purpose**	This metric aims to allow a CCG to explore how EPS could be deployed locally to derive the greatest benefit for patients and efficient prescription services.
2.2	**Evidence and Policy Base**	EPS enables prescribers such as GPs and practice nurses to send prescriptions electronically to a dispenser (such as a pharmacy) of the patient's choice. The prescription is then sent on to NHS Business Services Authority for payment. This makes the prescribing and dispensing process more efficient and convenient for patients and staff.
Section 3: Data		
3.1	**Data source**	NHS Business Services Authority
3.2	**Data owner & contact details**	nhsbsa.help@nhs.net
3.3	**Time Frame**	Refreshed quarterly with month end data Data available as at end of December 2014
3.4	**Data quality assurance**	Please see data quality assurance statement pertaining to NHSBSA accuracy NHSBSA Data: Data quality assurance

COMMUNITY SUPPORT: % of Practices submitting EPS

Section 1: Introduction / Overview		
1.1	**Title**	% of Practices submitting EPS
1.2	**MO Theme**	COMMUNITY SUPPORT
1.3	**Definition**	Percentage of practices undertaking electronic prescriptions (EPS)
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Number of practices who submitted EPS messages during the reporting period
1.6	**Denominator**	The total number of practices during the reporting period
1.7	**Methodology**	Numerator divided by denominator Represented as percentage of practices undertaking EPS Data is for GP practices active at any time during the reporting period
Section 2: Rationale		
2.1	**Purpose**	This metric aims to allow a CCG to explore how EPS could be deployed locally to derive the greatest benefit for patients and efficient prescription services.
2.2	**Evidence and Policy Base**	EPS enables prescribers such as GPs and practice nurses to send prescriptions electronically to a dispenser (such as a pharmacy) of the patient's choice. The prescription is then sent on to NHS Business Services Authority for payment. This makes the prescribing and dispensing process more efficient and convenient for patients and staff.
Section 3: Data		
3.1	**Data source**	NHS Business Services Authority
3.2	**Data owner & contact details**	nhsbsa.help@nhs.net
3.3	**Time Frame**	Refreshed quarterly with quarterly data Data available from October 2014
3.4	**Data quality assurance**	Please see data quality assurance statement pertaining to NHSBSA accuracy NHSBSA Data: Data quality assurance

COMMUNITY SUPPORT: % of Repeat Dispensing

Section 1: Introduction / Overview		
1.1	**Title**	% of Repeat Dispensing
1.2	**MO Theme**	COMMUNITY SUPPORT
1.3	**Definition**	Percentage of repeat dispensing items compared to all prescribing
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Number of repeat dispensing items prescribed and dispensed during the reporting period
1.6	**Denominator**	Total number of NHS prescribed and dispensed items during the reporting period
1.7	**Methodology**	Numerator divided by denominator Represented as percentage of repeat dispensing items (Other time periods and practice level data are available through NHSBSA Information Services Portal: https://apps.nhsbsa.nhs.uk/infosystems/welcome). catalogued under the Prescribing Monitoring reports
Section 2: Rationale		
2.1	**Purpose**	There is significant variation in the proportion of prescriptions managed in this way with some GP practices not making this service available to their patients. The use of this metric aims to increase the proportion of items provided this way and to ultimately free up GP and practice time.
2.2	**Evidence and Policy Base**	In 2002 it was estimated that up to 80% of all repeat prescriptions could be replaced with repeat dispensing over time, "yielding savings of up to 2.7 million hours of GP and practice time". Feedback from areas that have implemented repeat dispensing is that patients find the system more convenient. This opportunity was highlighted in the Transforming Primary care document published by DH and NHS England. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/304139/Transforming_primary_care.pdf Repeat dispensing enables GPs to issue a single prescription for up to a year, which pharmacists are then able to dispense in instalments. It provides pharmacists with a number of opportunities to have a discussion with the patient to determine if they still require the medicine and whether the patient is experiencing any problems with taking it.
Section 3: Data		
3.1	**Data source**	NHS Business Services Authority
3.2	**Data owner & contact details**	nhsbsa.help@nhs.net
3.3	**Time Frame**	Refreshed quarterly with 12 months accumulated data Data available from January 2014
3.4	**Data quality assurance**	Please see data quality assurance statement pertaining to NHSBSA accuracy NHSBSA Data: Data quality assurance

COMMUNITY SUPPORT: % of EPS Repeat Dispensing

Section 1: Introduction / Overview		
1.1	**Title**	% of EPS Repeat Dispensing
1.2	**MO Theme**	COMMUNITY SUPPORT
1.3	**Definition**	Percentage of all items prescribed as electronic repeat dispensing as a proportion of all electronic prescriptions
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Number of repeat dispensing items submitted via EPS during the reporting period
1.6	**Denominator**	The total number of items prescribed and dispensed via EPS during the reporting period
1.7	**Methodology**	Numerator divided by denominator Represented as percentage of EPS repeat dispensing items (Other time periods and practice level data are available through NHSBSA Information Services Portal: https://apps.nhsbsa.nhs.uk/infosystems/welcome). catalogued under the Prescribing Monitoring reports
Section 2: Rationale		
2.1	**Purpose**	Measure of the uptake and utilisation of repeat dispensing via EPS This comparator aims to allow a CCG to explore how repeat dispensing via EPS could be deployed locally to derive the greatest benefit for patients and efficient prescription services
2.2	**Evidence and Policy Base**	In 2002, it was estimated that up to 80% of all repeat prescriptions could be replaced with repeat dispensing over time, “yielding savings of up to 2.7 million hours of GP and practice time”. Feedback from areas that have implemented repeat dispensing is that patients find the system more convenient. Repeat dispensing enables GPs to issue a single prescription for up to a year, which pharmacists are then able to dispense in instalments. It provides pharmacists with a number of opportunities to have a discussion with the patient to determine if they still require the medicine and whether the patient is experiencing any problems with taking it.
Section 3: Data		
3.1	**Data source**	NHS Business Services Authority
3.2	**Data owner & contact details**	nhsbsa.help@nhs.net
3.3	**Time Frame**	Refreshed quarterly with 12 months accumulated data Data available from January 2014
3.4	**Data quality assurance**	Please see data quality assurance statement pertaining to NHSBSA accuracy NHSBSA Data: Data quality assurance

COMMUNITY SUPPORT: % of Pharmacies conducting MUR

Section 1: Introduction / Overview		
1.1	**Title**	% of Pharmacies conducting MUR
1.2	**MO Theme**	COMMUNITY SUPPORT
1.3	**Definition**	Percentage of pharmacies conducting MUR
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Number of pharmacies claiming for one or more MURs during the reporting period
1.6	**Denominator**	Total number of pharmacies submitting reimbursement claims during the reporting period
1.7	**Methodology**	Numerator divided by denominator (The average (i.e. the mean) number of pharmacies claiming for one or more MUR in the 12 month reporting period divided by the average number of pharmacies submitting reimbursement claims in the same 12 months. This provides a view of what is taking place on a monthly basis and the proportion of pharmacies undertaking the service regularly. This will be different to actual figures available in other publications). Represented as percentage of pharmacies conducting MUR Dispensing doctors and appliance contractors are not included From time period July 2015 to June 2016 onwards Local Pharmaceutical Services Pharmacies and Late Accounts (late submissions of prescriptions which do not pertain to the month they were submitted in) are included in the data NHSBSA use NHS geographical locations based on pharmacy postcodes in order to map pharmacies to a CCG
Section 2: Rationale		
2.1	**Purpose**	Ensure that patients receive support via MUR services to take their medicines as intended. Between 30% and 50% of medicines are not taken as intended.
2.2	**Evidence and Policy Base**	The MUR service is an Advanced service within the NHS community pharmacy contractual framework. It is a structured review that is undertaken by a pharmacist to help patients to manage their medicines more effectively. Part VIC of the NHS Drug Tariff (DT) for England and Wales explains the arrangements for MURs and states Payment will be made up to a maximum of 400 MURs per pharmacy for the period commencing on 1 April and ending on 31 March in any year. The DT is available through the link below. http://www.nhsbsa.nhs.uk/PrescriptionServices/4940.aspx
Section 3: Data		
3.1	**Data source**	NHS Business Services Authority
3.2	**Data owner & contact details**	nhsbsa.help@nhs.net
3.3	**Time Frame**	Refreshed quarterly with 12 months accumulated data Data available from January 2014
3.4	**Data quality assurance**	Please see data quality assurance statement pertaining to NHSBSA accuracy NHSBSA Data: Data quality assurance

COMMUNITY SUPPORT: Number of MUR per 1,000 dispensed items

Section 1: Introduction / Overview		
1.1	**Title**	Number of MUR per 1,000 dispensed items
1.2	**MO Theme**	COMMUNITY SUPPORT
1.3	**Definition**	Number of MUR per 1,000 prescription items dispensed
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Number of MUR claimed by pharmacies during the reporting period
1.6	**Denominator**	Number of items dispensed, taken from the pharmacy submission to NHSBSA for the reporting period divided by 1,000
1.7	**Methodology**	Numerator divided by denominator Represented as number of MUR per 1,000 prescription items dispensed Dispensing doctors and appliance contractors are not included From time period July 2015 to June 2016 onwards Local Pharmaceutical Services Pharmacies and Late Accounts (late submissions of prescriptions which do not pertain to the month they were submitted in) are included in the data. NHSBSA use NHS geographical locations based on pharmacy postcodes in order to map pharmacies to a CCG
Section 2: Rationale		
2.1	**Purpose**	Ensure that patients receive support via MUR services to take their medicines as intended. Between 30% and 50% of medicines are not taken as intended.
2.2	**Evidence and Policy Base**	The MUR service is an Advanced service within the NHS community pharmacy contractual framework. It is a structured review that is undertaken by a pharmacist to help patients to manage their medicines more effectively. Part VIC of the NHS Drug Tariff (DT) for England and Wales explains the arrangements for MURs and states payment will be made up to a maximum of 400 MURs per pharmacy for the period commencing on 1 April and ending on 31 March in any year The DT is available through the link below. http://www.nhsbsa.nhs.uk/PrescriptionServices/4940.aspx
Section 3: Data		
3.1	**Data source**	NHS Business Services Authority
3.2	**Data owner & contact details**	nhsbsa.help@nhs.net
3.3	**Time Frame**	Refreshed quarterly with 12 months accumulated data Data available from January 2014
3.4	**Data quality assurance**	Please see data quality assurance statement pertaining to NHSBSA accuracy NHSBSA Data: Data quality assurance

COMMUNITY SUPPORT: % of Pharmacies conducting NMS

Section 1: Introduction / Overview		
1.1	**Title**	% of Pharmacies conducting NMS
1.2	**MO Theme**	COMMUNITY SUPPORT
1.3	**Definition**	Percentage of pharmacies conducting NMS
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Number of pharmacies claiming for one or more NMS during the reporting period
1.6	**Denominator**	Total number of pharmacies submitting reimbursement claims during the reporting period
1.7	**Methodology**	Numerator divided by denominator (The average (i.e. the mean) number of pharmacies claiming for one or more NMS in the 12 month reporting period divided by the average number of pharmacies submitting reimbursement claims in the same 12 months. This provides a view of what is taking place on a monthly basis and the proportion of pharmacies undertaking the service regularly. This will be different to actual figures available in other publications). Represented as percentage of pharmacies conducting NMS Dispensing doctors and appliance contractors are not included From time period July 2015 to June 2016 onwards Local Pharmaceutical Services Pharmacies and Late Accounts (late submissions of prescriptions which do not pertain to the month they were submitted in) are included in the data. NHSBSA use NHS geographical locations based on pharmacy postcodes in order to map pharmacies to a CCG
Section 2: Rationale		
2.1	**Purpose**	Ensure that patients receive support via NMS to take their medicines as intended. Between 30% and 50% of medicines are not taken as intended.
2.2	**Evidence and Policy Base**	The New Medicine Service (NMS) was the fourth Advanced Service to be added to the NHS community pharmacy contract; it commenced on 1st October 2011. The service provides support for people with long-term conditions newly prescribed a medicine to help improve medicines adherence; it is initially focused on particular patient groups and conditions. The NMS service is designed to provide early support to patients to maximise the benefits of the medicine they have been prescribed. Part VIC of the NHS Drug Tariff (DT) for England and Wales explains the arrangements for NMS The DT is available through the link below. http://www.nhsbsa.nhs.uk/PrescriptionServices/4940.aspx
Section 3: Data		
3.1	**Data source**	NHS Business Services Authority
3.2	**Data owner & contact details**	nhsbsa.help@nhs.net
3.3	**Time Frame**	Refreshed quarterly with 12 months accumulated data Data available from January 2014
3.4	**Data quality assurance**	Please see data quality assurance statement pertaining to NHSBSA accuracy NHSBSA Data: Data quality assurance

COMMUNITY SUPPORT: Number of NMS per 1,000 dispensed items

Section 1: Introduction / Overview		
1.1	**Title**	Number of NMS per 1,000 dispensed items
1.2	**MO Theme**	COMMUNITY SUPPORT
1.3	**Definition**	Number of NMS per 1,000 prescription items dispensed
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Number of NMS claimed by pharmacies during the reporting period
1.6	**Denominator**	Number of items dispensed, taken from the pharmacy submission to NHSBSA for the reporting period divided by 1,000
1.7	**Methodology**	Numerator divided by denominator Represented as number of NMS per 1,000 prescription items dispensed Dispensing doctors and appliance contractors are not included From time period July 2015 to June 2016 onwards Local Pharmaceutical Services Pharmacies and Late Accounts (late submissions of prescriptions which do not pertain to the month they were submitted in) are included in the data. NHSBSA use NHS geographical locations based on pharmacy postcodes in order to map pharmacies to a CCG
Section 2: Rationale		
2.1	**Purpose**	Ensure that patients receive support via NMS to take their medicines as intended. Between 30% and 50% of medicines are not taken as intended.
2.2	**Evidence and Policy Base**	The New Medicine Service (NMS) was the fourth Advanced Service to be added to the NHS community pharmacy contract; it commenced on 1st October 2011. The service provides support for people with long-term conditions newly prescribed a medicine to help improve medicines adherence; it is initially focused on particular patient groups and conditions. The NMS service is designed to provide early support to patients to maximise the benefits of the medicine they have been prescribed. Part VIC of the NHS Drug Tariff (DT) for England and Wales explains the arrangements for NMS. The DT is available through the link below. http://www.nhsbsa.nhs.uk/PrescriptionServices/4940.aspx
Section 3: Data		
3.1	**Data source**	NHS Business Services Authority
3.2	**Data owner & contact details**	nhsbsa.help@nhs.net
3.3	**Time Frame**	Refreshed quarterly with 12 months accumulated data Data available from January 2014
3.4	**Data quality assurance**	Please see data quality assurance statement pertaining to NHSBSA accuracy NHSBSA Data: Data quality assurance

CVD/CHD: Atrial fibrillation (AF007) % achieving upper threshold or above

Section 1: Introduction / Overview		
1.1	**Title**	Atrial fibrillation (AF007) % achieving upper threshold or above
1.2	**MO Theme**	CVD/CHD
1.3	**Definition**	The percentage of practices in a CCG that achieve upper threshold or above (70% or more inclusive of exceptions) for QOF indicator AF007
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Number of practices in a CCG that achieve upper threshold or above for QOF indicator AF007 (achievement of 70% or more inclusive of exceptions)
1.6	**Denominator**	Total number of practices in a CCG with eligible patients for QOF indicator AF007
1.7	**Methodology**	Numerator divided by denominator Represented as the percentage of practices achieving upper threshold or above inclusive of exceptions The comparator is inclusive of exceptions. In other words, it includes all the patients who satisfy the denominator criteria, even if some have been "excepted". "Exceptions" relate to registered patients who are on the relevant disease register or in the target population group and would ordinarily be included in the indicator denominator, but who are excepted by the contractor on the basis of one or more of the exception criteria. Although patients may be excepted from the denominator, they should still be the recipients of best clinical care and practice. See 2015/16 General Medical Services (GMS) contract Quality and Outcomes Framework (QOF): Guidance for GMS contract 2015/16 (NHS Employers) http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf (page 12 and Section 5 (pages 138 - 145)) for full details.
Section 2: Rationale		
2.1	**Purpose**	The Quality and Outcomes Framework (QOF) rewards contractors for the provision of quality care and helps to standardise improvements in the delivery of primary medical services. Contractor participation in QOF is voluntary. Within the QOF there are a number of indicators that are associated with the effective and/or appropriate use of medicines. NB: For 2015/16 QOF, points are awarded for AF007 for an achievement of 40 to 70% with a maximum of 12 points awarded for achievement of 70% or more. http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf
2.2	**Evidence and Policy Base**	Atrial fibrillation is the most common sustained cardiac arrhythmia and if left untreated is a significant risk factor for stroke and other morbidities. Existing evidence suggests that many patients with AF remain untreated or treated inappropriately. CCGs with a comparatively higher score may be deploying systematic process to identify and treat patients with AF.
Section 3: Data		
3.1	**Data source**	NHS Digital
3.2	**Data owner & contact details**	QOF CCG level table. NHS Digital website http://qof.digital.nhs.uk/ http://www.content.digital.nhs.uk/catalogue/PUB22266
3.3	**Time Frame**	2015/16 (NB: Refreshed yearly each November with latest annual data) Data available from April 2015
3.4	**Data quality assurance**	None provided

CVD/CHD: Atrial fibrillation (AF007) % underlying achievement

Section 1: Introduction / Overview		
1.1	**Title**	Atrial fibrillation (AF007) % underlying achievement
1.2	**MO Theme**	CVD/CHD
1.3	**Definition**	Percentage underlying achievement at CCG level for QOF indicator AF007 inclusive of exceptions
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Number of patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more who are currently treated with anti-coagulation drug therapy
1.6	**Denominator**	Number of patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more inclusive of exceptions
1.7	**Methodology**	Numerator divided by denominator Represented as a percentage underlying achievement level inclusive of exceptions The denominator is inclusive of exceptions. In other words, it includes all the patients who satisfy the denominator criteria, even if some have been "excepted". "Exceptions" relate to registered patients who are on the relevant disease register or in the target population group and would ordinarily be included in the indicator denominator, but who are excepted by the contractor on the basis of one or more of the exception criteria. Although patients may be excepted from the denominator, they should still be the recipients of best clinical care and practice. See 2015/16 General Medical Services (GMS) contract Quality and Outcomes Framework (QOF): Guidance for GMS contract 2015/16 (NHS Employers) http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf (page 12 and Section 5 (pages 138 - 145)) for full details.
Section 2: Rationale		
2.1	**Purpose**	The Quality and Outcomes Framework (QOF) rewards contractors for the provision of quality care and helps to standardise improvements in the delivery of primary medical services. Contractor participation in QOF is voluntary. Within the QOF there are a number of indicators that are associated with the effective and/or appropriate use of medicines. NB: For 2015/16 QOF, points are awarded for AF007 for an achievement of 40 to 70% with a maximum of 12 points awarded for achievement of 70% or more. http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf
2.2	**Evidence and Policy Base**	Atrial fibrillation is the most common sustained cardiac arrhythmia and if left untreated is a significant risk factor for stroke and other morbidities. Existing evidence suggests that many patients with AF remain untreated or treated inappropriately. CCGs with a comparatively higher score may be deploying systematic process to identify and treat patients with AF.
Section 3: Data		
3.1	**Data source**	NHS Digital
3.2	**Data owner & contact details**	QOF CCG level table. NHS Digital website http://qof.digital.nhs.uk/ http://www.content.digital.nhs.uk/catalogue/PUB22266
3.3	**Time Frame**	2015/16 (NB: Refreshed yearly each November with latest annual data) Data available from April 2015
3.4	**Data quality assurance**	None provided

CVD/CHD: Heart failure (HF003) % achieving upper threshold or above

Section 1: Introduction / Overview		
1.1	**Title**	Heart failure (HF003) % achieving upper threshold or above
1.2	**MO Theme**	CVD/CHD
1.3	**Definition**	The percentage of practices in a CCG that achieve upper threshold or above (100% inclusive of exceptions) for QOF indicator HF003
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Number of practices in a CCG that achieve upper threshold or above for QOF indicator HF003 (achievement of 100% inclusive of exceptions)
1.6	**Denominator**	Total number of practices in a CCG with eligible patients for QOF indicator HF003
1.7	**Methodology**	Numerator divided by denominator Represented as a percentage of practices achieving upper threshold or above inclusive of exceptions The comparator is inclusive of exceptions. In other words, it includes all the patients who satisfy the denominator criteria, even if some have been "excepted". "Exceptions" relate to registered patients who are on the relevant disease register or in the target population group and would ordinarily be included in the indicator denominator, but who are excepted by the contractor on the basis of one or more of the exception criteria. Although patients may be excepted from the denominator, they should still be the recipients of best clinical care and practice. See 2015/16 General Medical Services (GMS) contract Quality and Outcomes Framework (QOF): Guidance for GMS contract 2015/16 (NHS Employers) http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf (page 12 and Section 5 (pages 138 - 145)) for full details.
Section 2: Rationale		
2.1	**Purpose**	The Quality and Outcomes Framework (QOF) rewards contractors for the provision of quality care and helps to standardise improvements in the delivery of primary medical services. Contractor participation in QOF is voluntary. Within the QOF there are a number of indicators that are associated with the effective and/or appropriate use of medicines. NB: For 2015/16 QOF, points are awarded for HF003 for an achievement of 60 to 100% with a maximum of 10 points awarded for achievement of 100% or more. http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf
2.2	**Evidence and Policy Base**	In most cases, heart failure is a lifelong condition that cannot be cured. Treatment therefore aims to find a combination of measures, including lifestyle changes, medicines, devices or surgery that will improve heart function or help the body get rid of excess water. Effective treatment for heart failure can have the following benefits: •it helps make the heart stronger •it improves your symptoms •it reduces the risk of a flare-up •it allows people with the condition to live longer and fuller lives This indicator was chosen because existing evidence suggests that many patients with HF remain untreated or treated inappropriately. CCGs with a comparatively higher score may be deploying systematic process to identify and treat patients with HF.
Section 3: Data		
3.1	**Data source**	NHS Digital
3.2	**Data owner & contact details**	QOF CCG level table. NHS Digital website http://qof.digital.nhs.uk/ http://www.content.digital.nhs.uk/catalogue/PUB22266
3.3	**Time Frame**	2015/16 (NB: Refreshed yearly each November with latest annual data) Data available from April 2013
3.4	**Data quality assurance**	None provided

CVD/CHD: Heart failure (HF003) % underlying achievement

Section 1: Introduction / Overview		
1.1	**Title**	Heart failure (HF003) % underlying achievement
1.2	**MO Theme**	CVD/CHD
1.3	**Definition**	Percentage underlying achievement at CCG level for QOF indicator HF003 inclusive of exceptions
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Number of patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction who are currently treated with an ACE-I or ARB
1.6	**Denominator**	Number of patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction inclusive of exceptions
1.7	**Methodology**	Numerator divided by denominator Represented as the percentage underlying achievement level inclusive of exceptions The denominator is inclusive of exceptions. In other words, it includes all the patients who satisfy the denominator criteria, even if some have been "excepted". "Exceptions" relate to registered patients who are on the relevant disease register or in the target population group and would ordinarily be included in the indicator denominator, but who are excepted by the contractor on the basis of one or more of the exception criteria. Although patients may be excepted from the denominator, they should still be the recipients of best clinical care and practice. See 2015/16 General Medical Services (GMS) contract Quality and Outcomes Framework (QOF): Guidance for GMS contract 2015/16 (NHS Employers) http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf (page 12 and Section 5 (pages 138 - 145)) for full details.
Section 2: Rationale		
2.1	**Purpose**	The Quality and Outcomes Framework (QOF) rewards contractors for the provision of quality care and helps to standardise improvements in the delivery of primary medical services. Contractor participation in QOF is voluntary. Within the QOF there are a number of indicators that are associated with the effective and/or appropriate use of medicines. NB: For 2015/16 QOF, points are awarded for HF003 for an achievement of 60 to 100% with a maximum of 10 points awarded for achievement of 100% or more. http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf
2.2	**Evidence and Policy Base**	In most cases, heart failure is a lifelong condition that cannot be cured. Treatment therefore aims to find a combination of measures, including lifestyle changes, medicines, devices or surgery that will improve heart function or help the body get rid of excess water. Effective treatment for heart failure can have the following benefits: •it helps make the heart stronger •it improves your symptoms •it reduces the risk of a flare-up •it allows people with the condition to live longer and fuller lives This indicator was chosen because existing evidence suggests that many patients with HF remain untreated or treated inappropriately. CCGs with a comparatively higher score may be deploying systematic process to identify and treat patients with HF.
Section 3: Data		
3.1	**Data source**	NHS Digital
3.2	**Data owner & contact details**	QOF CCG level table. NHS Digital website http://qof.digital.nhs.uk/ http://www.content.digital.nhs.uk/catalogue/PUB22266
3.3	**Time Frame**	2015/16 (NB: Refreshed yearly each November with latest annual data) Data available from April 2013
3.4	**Data quality assurance**	None provided

CVD/CHD: Heart failure (HF004) % achieving upper threshold or above

Section 1: Introduction / Overview		
1.1	**Title**	Heart failure (HF004) % achieving upper threshold or above
1.2	**MO Theme**	CVD/CHD
1.3	**Definition**	The percentage of practices in a CCG that achieve upper threshold or above (65% or more inclusive of exceptions) for QOF indicator HF004
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Number of practices in a CCG that achieve upper threshold or above for QOF indicator HF004 (achievement of 65% or more inclusive of exceptions)
1.6	**Denominator**	Total number of practices in a CCG with eligible patients for QOF indicator HF004
1.7	**Methodology**	Numerator divided by denominator Represented as the percentage of practices achieving upper threshold or above inclusive of exceptions The comparator is inclusive of exceptions. In other words, it includes all the patients who satisfy the denominator criteria, even if some have been "excepted". "Exceptions" relate to registered patients who are on the relevant disease register or in the target population group and would ordinarily be included in the indicator denominator, but who are excepted by the contractor on the basis of one or more of the exception criteria. Although patients may be excepted from the denominator, they should still be the recipients of best clinical care and practice. See 2015/16 General Medical Services (GMS) contract Quality and Outcomes Framework (QOF): Guidance for GMS contract 2015/16 (NHS Employers) http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf (page 12 and Section 5 (pages 138 - 145)) for full details.
Section 2: Rationale		
2.1	**Purpose**	The Quality and Outcomes Framework (QOF) rewards contractors for the provision of quality care and helps to standardise improvements in the delivery of primary medical services. Contractor participation in QOF is voluntary. Within the QOF there are a number of indicators that are associated with the effective and/or appropriate use of medicines. NB: For 2015/16 QOF, points are awarded for HF004 for an achievement of 40 to 65% with a maximum of 9 points awarded for achievement of 65% or more. http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf
2.2	**Evidence and Policy Base**	In most cases, heart failure is a lifelong condition that cannot be cured. Treatment therefore aims to find a combination of measures, including lifestyle changes, medicines, devices or surgery that will improve heart function or help the body get rid of excess water. Effective treatment for heart failure can have the following benefits: •it helps make the heart stronger •it improves your symptoms •it reduces the risk of a flare-up •it allows people with the condition to live longer and fuller lives This indicator was chosen because existing evidence suggests that many patients with HF remain untreated or treated inappropriately. CCGs with a comparatively higher score may be deploying systematic process to identify and treat patients with HF.
Section 3: Data		
3.1	**Data source**	NHS Digital
3.2	**Data owner & contact details**	QOF CCG level table. NHS Digital website http://qof.digital.nhs.uk/ http://www.content.digital.nhs.uk/catalogue/PUB22266
3.3	**Time Frame**	2015/16 (NB: Refreshed yearly each November with latest annual data) Data available from April 2013
3.4	**Data quality assurance**	None provided

CVD/CHD: Heart failure (HF004) % underlying achievement

Section 1: Introduction / Overview		
1.1	**Title**	Heart failure (HF004) % underlying achievement
1.2	**MO Theme**	CVD/CHD
1.3	**Definition**	Percentage underlying achievement at CCG level for QOF indicator HF004 inclusive of exceptions
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Number of patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction who are currently treated with an ACE-I or ARB who are additionally currently treated with a beta-blocker licensed for heart failure
1.6	**Denominator**	Number of patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction who are currently treated with an ACE-I or ARB inclusive of exceptions
1.7	**Methodology**	Numerator divided by denominator Represented as the percentage underlying achievement level inclusive of exceptions The denominator is inclusive of exceptions. In other words, it includes all the patients who satisfy the denominator criteria, even if some have been "excepted". "Exceptions" relate to registered patients who are on the relevant disease register or in the target population group and would ordinarily be included in the indicator denominator, but who are excepted by the contractor on the basis of one or more of the exception criteria. Although patients may be excepted from the denominator, they should still be the recipients of best clinical care and practice. See 2015/16 General Medical Services (GMS) contract Quality and Outcomes Framework (QOF): Guidance for GMS contract 2015/16 (NHS Employers) http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf (page 12 and Section 5 (pages 138 - 145)) for full details.
Section 2: Rationale		
2.1	**Purpose**	The Quality and Outcomes Framework (QOF) rewards contractors for the provision of quality care and helps to standardise improvements in the delivery of primary medical services. Contractor participation in QOF is voluntary. Within the QOF there are a number of indicators that are associated with the effective and/or appropriate use of medicines. NB: For 2015/16 QOF, points are awarded for HF004 for an achievement of 40 to 65% with a maximum of 9 points awarded for achievement of 65% or more. http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf
2.2	**Evidence and Policy Base**	In most cases, heart failure is a lifelong condition that cannot be cured. Treatment therefore aims to find a combination of measures, including lifestyle changes, medicines, devices or surgery that will improve heart function or help the body get rid of excess water. Effective treatment for heart failure can have the following benefits: •it helps make the heart stronger •it improves your symptoms •it reduces the risk of a flare-up •it allows people with the condition to live longer and fuller lives This indicator was chosen because existing evidence suggests that many patients with HF remain untreated or treated inappropriately. CCGs with a comparatively higher score may be deploying systematic process to identify and treat patients with HF.
Section 3: Data		
3.1	**Data source**	NHS Digital
3.2	**Data owner & contact details**	QOF CCG level table. NHS Digital website http://qof.digital.nhs.uk/ http://www.content.digital.nhs.uk/catalogue/PUB22266
3.3	**Time Frame**	2015/16 (NB: Refreshed yearly each November with latest annual data) Data available from April 2013
3.4	**Data quality assurance**	None provided

CVD/CHD: NSAIDS: Ibuprofen & Naproxen % items

Section 1: Introduction / Overview		
1.1	**Title**	NSAIDS: Ibuprofen & Naproxen % items
1.2	**MO Theme**	CVD/CHD
1.3	**Definition**	Number of prescription items for ibuprofen and naproxen as a percentage of the total number of prescription items for all NSAIDs
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Number of prescription items for ibuprofen and naproxen (sub-set of BNF section 10.1.1) **BNF Name** — **BNF Code** Ibuprofen — 1001010J0 Ibuprofen Lysine — 1001010AD Naproxen — 1001010P0 Naproxen Sodium — 100101070
1.6	**Denominator**	Number of prescription items for BNF section 10.1.1 (non-steroidal anti-inflammatory drugs) **BNF Name** — **BNF Code** Non-Steroidal Anti-Inflammatory Drugs — 100101
1.7	**Methodology**	Numerator divided by denominator Represented as percentage of ibuprofen and naproxen items (Other time periods and practice level data are available through NHSBSA Information Services Portal: https://apps.nhsbsa.nhs.uk/infosystems/welcome) catalogued under the MOKTT reports
Section 2: Rationale		
2.1	**Purpose**	The purpose of the prescribing comparator is to support the evidence and messages included in the 'Key therapeutic topics – Medicines management options for local implementation' publication by highlighting variation in prescribing across organisations, with the aim of reducing variation and a movement of the mean in the appropriate direction over time. The comparator is intended to support organisations and prescribers in reviewing the appropriateness of current prescribing, revise prescribing where appropriate and monitor implementation.
2.2	**Evidence and Policy Base**	There are long-standing and well-recognised gastrointestinal and renal safety concerns with all NSAIDs. There is also an increased risk of cardiovascular events with many NSAIDs, including COX-2 inhibitors and some traditional NSAIDs. The MHRA recommends that the lowest effective dose of NSAID should be prescribed for the shortest time necessary for control of symptoms. In 2005, a review by the European Medicines Agency identified an increased risk of thrombotic events, such as heart attack and stroke, with COX-2 inhibitors. In 2006, they also concluded that a small increased risk of thrombotic events could not be excluded with non-selective NSAIDs, including diclofenac, particularly when they are used at high doses for long-term treatment. This risk does not appear to be shared by ibuprofen at 1200 mg per day or less, or naproxen at 1000 mg per day. See the NICE website for the latest update of the Medicines and Prescribing Centre publication http://www.nice.org.uk/mpc/keytherapeutictopics/keyTherapeuticTopics.jsp This comparator is taken from the Medicines Optimisation Key Therapeutic Topics (MO KTT) Comparators 2015/16 developed by NHS Digital http://content.digital.nhs.uk/media/18422/Descriptions-and-Specifications-201516/pdf/Descriptions_and_Specifications_2015_16.pdf
Section 3: Data		
3.1	**Data source**	NHS Business Services Authority
3.2	**Data owner & contact details**	nhsbsa.help@nhs.net
3.3	**Time Frame**	Refreshed quarterly with quarterly data Data available from October 2014
3.4	**Data quality assurance**	Please see data quality assurance statement pertaining to NHSBSA accuracy NHSBSA Data: Data quality assurance

CVD/CHD: Oral Anticoagulants % items

Section 1: Introduction / Overview		
1.1	**Title**	Oral Anticoagulants % items
1.2	**MO Theme**	CVD/CHD
1.3	**Definition**	Number of prescription items for apixaban, dabigatran etexilate, edoxaban and rivaroxaban as a percentage of the total number of prescription items for apixaban, dabigatran etexilate, edoxaban, rivaroxaban and warfarin sodium
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Number of prescription items for apixaban, dabigatran etexilate, edoxaban and rivaroxaban **BNF Name** — **BNF Code** Apixaban — 0208020Z0 Dabigatran etexilate — 0208020X0 Edoxaban — 0208020AA Rivaroxaban — 0208020Y0
1.6	**Denominator**	Number of prescription items for apixaban, dabigatran etexilate, edoxaban, rivaroxaban and warfarin sodium **BNF Name** — **BNF Code** Apixaban — 0208020Z0 Dabigatran etexilate — 0208020X0 Edoxaban — 0208020AA Rivaroxaban — 0208020Y0 Warfarin sodium — 0208020V0
1.7	**Methodology**	Numerator divided by denominator Represented as percentage of apixaban, dabigatran etexilate, edoxaban and rivaroxaban items
Section 2: Rationale		
2.1	**Purpose**	Comparator highlights the variation in uptake of newer and alternative anticoagulants appraised by NICE and allows for the monitoring of uptake over time.
2.2	**Evidence and Policy Base**	This indicator was chosen to highlight uptake of medicines appraised by NICE. Most patients with atrial fibrillation (AF) will require anticoagulation therapy to reduce their risk of stroke. Increasing the range of treatment options available will support a patient-centred approach to treatment and improve outcomes by increasing the proportion of patients regularly taking anticoagulants. The four oral anticoagulant medicines (OACs) have recently been appraised by NICE and are an option, alongside warfarin, for the management of patients with Atrial Fibrillation (AF). In time, we would hope to highlight how many patients with a diagnosis of AF are not receiving any anticoagulation (e.g. via the NHS IQ GRASP-AF tool (http://www.nottingham.ac.uk/primis/) For a variety of reasons, evidence suggests that there are a number of patients that have a diagnosis of Atrial Fibrillation but are not receiving any anticoagulant medication. Patients should have the range of medicines made available to them and a shared decision reached between the prescriber and the patient as to which meets their individual needs and which medicines they are most likely to be able to adhere to. Dabigatran etexilate (www.nice.org.uk/TA249) and rivaroxaban (www.nice.org.uk/TA256) were appraised by NICE in 2012, apixaban (www.nice.org.uk/TA275) was appraised by NICE in 2013 and edoxaban (www.nice/TA355) was appraised by NICE in 2015 for the prevention of stroke and systemic embolism in people with nonvalvular atrial fibrillation. This metric adopts a “per cent use” approach for prescription items of apixiban, dabigatran etexilate, edoxaban and rivaroxaban. These medicines are recommended by NICE as an option in the management of AF and therefore this metric measures the variation in the uptake of these drugs in comparison with Warfarin. These medicines are also recommended by NICE as options for the management of other conditions as detailed below: Dabigatran (TA 157), rivaroxaban (TA 170) and apixaban (TA 245) have also been appraised by NICE for the prevention of thromboembolism following hip or knee replacement. Dabigatran (TA 327), rivaroxaban (TA 261), apixaban (TA 341) and edoxaban (TA 354) have also been appraised by NICE for the treatment and prevention of deep-vein thrombosis and prevention of recurrent deep-vein thrombosis and pulmonary embolism. In addition rivaroxaban (TA 287) has been appraised by NICE for the treatment of pulmonary embolism. Rivaroxaban (TA 335) has also been appraised by NICE for preventing adverse outcomes after acute management of acute coronary syndrome.

		The NHS Innovation Review, Innovation Health and Wealth (December 2011), was launched by the Prime Minister alongside the Strategy for UK Life Sciences (December 2011). The document highlights eight areas where it makes recommendations; one of which is that we should reduce variation in the NHS, and drive greater compliance with guidance from the National Institute for Health and Clinical Excellence. This indicator has been chosen to show the variation in the uptake of OACs and therefore highlight where CCGs are not making these anticoagulant medicines available to patients in their area. It should be noted that NICE have positively appraised these medicines as options for treatment. The metric is likely to highlight prescribing of OACs for atrial fibrillation, and possibly treatment and prevention of DVT/PE in primary care. Use of OACs for prevention of venous thromboembolism post hip or knee surgery will be mostly or entirely within secondary care and therefore not reflected in the metric.
Section 3: Data		
3.1	**Data source**	NHS Business Services Authority
3.2	**Data owner & contact details**	nhsbsa.help@nhs.net
3.3	**Time Frame**	Refreshed quarterly with quarterly data Data available from October 2014
3.4	**Data quality assurance**	Please see data quality assurance statement pertaining to NHSBSA accuracy NHSBSA Data: Data quality assurance

DIABETES: Diabetes Mellitus (DM009) % achieving upper threshold or above

Section 1: Introduction / Overview		
1.1	**Title**	Diabetes Mellitus (DM009) % achieving upper threshold or above
1.2	**MO Theme**	DIABETES
1.3	**Definition**	The percentage of practices in a CCG that achieve upper threshold or above (92% or more inclusive of exceptions) for QOF indicator DM009
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Number of practices in a CCG that achieve upper threshold or above for QOF indicator DM009 (achievement of 92% or more inclusive of exceptions)
1.6	**Denominator**	Total number of practices in a CCG with eligible patients for QOF indicator DM009
1.7	**Methodology**	Numerator divided by denominator Represented as the percentage of practices achieving upper threshold or above The comparator is inclusive of exceptions. In other words, it includes all the patients who satisfy the denominator criteria, even if some have been "excepted". "Exceptions" relate to registered patients who are on the relevant disease register or in the target population group and would ordinarily be included in the indicator denominator, but who are excepted by the contractor on the basis of one or more of the exception criteria. Although patients may be excepted from the denominator, they should still be the recipients of best clinical care and practice. See 2015/16 General Medical Services (GMS) contract Quality and Outcomes Framework (QOF): Guidance for GMS contract 2015/16 (NHS Employers) http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf (page 12 and Section 5 (pages 138 - 145)) for full details.
Section 2: Rationale		
2.1	**Purpose**	The Quality and Outcomes Framework (QOF) rewards contractors for the provision of quality care and helps to standardise improvements in the delivery of primary medical services. Contractor participation in QOF is voluntary. Within the QOF there are a number of indicators that are associated with the effective and/or appropriate use of medicines. NB: For 2015/16 QOF, points are awarded for DM009 for an achievement of 52 to 92% with a maximum of 10 points awarded for achievement of 92% or more. http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf
2.2	**Evidence and Policy Base**	Diabetes is a lifelong condition that causes a person's blood sugar level to become too high. There are two main types of diabetes – type 1 diabetes and type 2 diabetes. There are 3.5 million people diagnosed with diabetes in the UK and an estimated 549,000 people who have the condition, but don't know it (Diabetes UK). Uncontrolled diabetes can result in devastating complications and reduced quality of life for patients and increased mortality. In addition it places great strain on NHS resources. This indicator was chosen because existing evidence suggests that many patients with diabetes remain untreated or treated inappropriately. CCGs with a comparatively higher score may be deploying systematic process to identify and treat patients with diabetes.
Section 3: Data		
3.1	**Data source**	NHS Digital
3.2	**Data owner & contact details**	QOF CCG level table. NHS Digital website http://qof.digital.nhs.uk/ http://www.content.digital.nhs.uk/catalogue/PUB22266
3.3	**Time Frame**	2015/16 (NB: Refreshed yearly each November with latest annual data) Data available from April 2013
3.4	**Data quality assurance**	None provided

DIABETES: Diabetes Mellitus (DM009) % underlying achievement

Section 1: Introduction / Overview		
1.1	**Title**	Diabetes Mellitus (DM009) % underlying achievement
1.2	**MO Theme**	DIABETES
1.3	**Definition**	Percentage underlying achievement at CCG level for QOF indicator DM009 inclusive of exceptions
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Number of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months
1.6	**Denominator**	Number of patients with diabetes on the register (inclusive of exceptions)
1.7	**Methodology**	Numerator divided by denominator Represented as the percentage underlying achievement level inclusive of exceptions The denominator is inclusive of exceptions. In other words, it includes all the patients who satisfy the denominator criteria, even if some have been "excepted". "Exceptions" relate to registered patients who are on the relevant disease register or in the target population group and would ordinarily be included in the indicator denominator, but who are excepted by the contractor on the basis of one or more of the exception criteria. Although patients may be excepted from the denominator, they should still be the recipients of best clinical care and practice. See 2015/16 General Medical Services (GMS) contract Quality and Outcomes Framework (QOF): Guidance for GMS contract 2015/16 (NHS Employers) http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf (page 12 and Section 5 (pages 138 - 145)) for full details.
Section 2: Rationale		
2.1	**Purpose**	The Quality and Outcomes Framework (QOF) rewards contractors for the provision of quality care and helps to standardise improvements in the delivery of primary medical services. Contractor participation in QOF is voluntary. Within the QOF there are a number of indicators that are associated with the effective and/or appropriate use of medicines. NB: For 2015/16 QOF, points are awarded for DM009 for an achievement of 52 to 92% with a maximum of 10 points awarded for achievement of 92% or more. http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf
2.2	**Evidence and Policy Base**	Diabetes is a lifelong condition that causes a person's blood sugar level to become too high. There are two main types of diabetes – type 1 diabetes and type 2 diabetes. There are 3.5 million people diagnosed with diabetes in the UK and an estimated 549,000 people who have the condition, but don't know it (Diabetes UK). Uncontrolled diabetes can result in devastating complications and reduced quality of life for patients and increased mortality. In addition it places great strain on NHS resources. This indicator was chosen because existing evidence suggests that many patients with diabetes remain untreated or treated inappropriately. CCGs with a comparatively higher score may be deploying systematic process to identify and treat patients with diabetes.
Section 3: Data		
3.1	**Data source**	NHS Digital
3.2	**Data owner & contact details**	QOF CCG level table. NHS Digital website http://qof.digital.nhs.uk/ http://www.content.digital.nhs.uk/catalogue/PUB22266
3.3	**Time Frame**	2015/16 (NB: Refreshed yearly each November with latest annual data) Data available from April 2013
3.4	**Data quality assurance**	None provided

DIABETES: Emergency Diabetes Admissions

Section 1: Introduction / Overview		
1.1	**Title**	Emergency Diabetes Admissions
1.2	**MO Theme**	DIABETES
1.3	**Definition**	The number of emergency attendances for diabetes per 100 patients on the practice QOF diabetes disease register
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Count of completed spells and sum of PBR tariff where a) admission method is emergency (21, 22, 23, 24, 28); b) patient classification is inpatient (1); c) ICD10 primary diagnosis code is in range E10-E14
1.6	**Denominator**	Number of patients (17+) on practice QOF diabetes disease register as of 31 March 2015
1.7	**Methodology**	Numerator divided by denominator Represented as emergency diabetes admissions per 100 patients on practice QOF diabetes disease register
Section 2: Rationale		
2.1	**Purpose**	To highlight and compare the rate of hospital emergency admissions due to complications associated with diabetes as a proxy for the effective management of the condition.
2.2	**Evidence and Policy Base**	Diabetes is a lifelong condition that causes a person's blood sugar level to become too high. There are two main types of diabetes – type 1 diabetes and type 2 diabetes. There are 3.5 million people diagnosed with diabetes in the UK and an estimated 549,000 people who have the condition, but don't know it (Diabetes UK). Uncontrolled diabetes can result in complications and reduced quality of life for patients and increased mortality. In addition it places a burden on NHS resources. If diabetes is uncontrolled this can lead to fluctuations in blood sugar levels potentially resulting in hospital admission. Emergency admissions due to diabetes can therefore be used to an extent as a proxy for the quality of management of the condition, including the optimal use of medicines.
Section 3: Data		
3.1	**Data source**	NHS England General Practice High Level Indicators https://www.primarycare.nhs.uk/
3.2	**Data owner & contact details**	NHS England General Practice High Level Indicators https://www.primarycare.nhs.uk/
3.3	**Time Frame**	Refreshed periodically with 12 months accumulated data Data available from April 2013
3.4	**Data quality assurance**	None provided

MENTAL HEALTH: Antidepressants (selected): ADQ/STAR PU (ADQ based)

Section 1: Introduction / Overview		
1.1	**Title**	Antidepressants (selected): ADQ/STAR PU (ADQ based)
1.2	**MO Theme**	MENTAL HEALTH
1.3	**Definition**	Number of average daily quantities (ADQs) for selected antidepressant prescribing per antidepressants (BNF 4.3 sub-set) ADQ based STAR-PU
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Total average daily quantities (ADQ) usage for selected antidepressants (BNF 4.3 sub-set) **BNF Name** — **BNF Code** Antidepressant Drugs — 0403 excluding: **BNF Name** — **BNF Code** Amitriptyline Hydrochloride — 0403010B0 Clomipramine Hydrochloride — 0403010F0 Imipramine Hydrochloride — 0403010N0 Nortriptyline — 0403010V0 Trimipramine — 0403010Y0 Monoamine-Oxidase Inhibitors (MAOIs) — 040302 Flupentixol Hydrochloride — 0403040F0
1.6	**Denominator**	Number of antidepressant (BNF 4.3 sub-set) ADQ based STAR-PU **Antidepressant (BNF 4.3 sub-set) ADQ based STAR-PU (2013 weighting)** **Age band** — **Male** — **Female** 0-4 — 0.0 — 0.0 5-14 — 0.1 — 0.1 15-24 — 4.7 — 11.4 25-34 — 12.9 — 27.1 35-44 — 19.8 — 42.6 45-54 — 22.7 — 49.8 55-64 — 23.7 — 44.9 65-74 — 18.1 — 35.4 75+ — 18.7 — 33.4
1.7	**Methodology**	Numerator divided by denominator Represented as antidepressants ADQ / STAR-PU STAR-PUs are weightings devised by NHS Digital and the following link provides further information regarding Prescribing Measures http://content.digital.nhs.uk/media/10027/Prescribing-measures-booklet/pdf/pres-meas-book-v7.pdf NHSBSA update list size information throughout a financial quarter and these patient list sizes are only fully refreshed at the end of that financial quarter; therefore STAR-PU values used in this comparator are based on the latest available complete patient list size. (Other time periods and practice level data are available through NHSBSA Information Services Portal: https://apps.nhsbsa.nhs.uk/infosystems/welcome). catalogued under the MOKTT reports
Section 2: Rationale		

2.1	**Purpose**	The purpose of the prescribing comparator is to support the evidence and messages included in the 'Key therapeutic topics – Medicines management options for local implementation' publication by highlighting variation in prescribing across organisations, with the aim of reducing variation and a movement of the mean in the appropriate direction over time. The comparator is intended to support organisations and prescribers in reviewing the appropriateness of current prescribing, revise prescribing where appropriate and monitor implementation.
2.2	**Evidence and Policy Base**	Depression affects people in different ways and can cause a wide variety of symptoms. They range from lasting feelings of sadness and hopelessness, to losing interest in the things patients used to enjoy and feeling very tearful. Many people with depression also have symptoms of anxiety. Depression is quite common and affects about 1 in 10 of us at some point. It affects men and women, young and old. Depression can also strike children. Studies have shown that about 4% of children aged 5 to 16 in the UK are anxious or depressed. Treatment for depression involves either medication or talking treatments, or usually a combination of the two. The prevalence of depression and the devastating symptoms and outcomes it can have for patients, aligned with the NHS resources required to treat depression make it valid for inclusion in this dashboard. Mental Health is also a priority in the NHS England business plan. This comparator is taken from the Medicines Optimisation Key Therapeutic Topics (MO KTT) Comparators 2015/16 developed by NHS Digital http://content.digital.nhs.uk/media/18422/Descriptions-and-Specifications-201516/pdf/Descriptions_and_Specifications_2015_16.pdf
Section 3: Data		
3.1	**Data source**	NHS Business Services Authority
3.2	**Data owner & contact details**	nhsbsa.help@nhs.net
3.3	**Time Frame**	Refreshed quarterly with quarterly data Data available from April 2013
3.4	**Data quality assurance**	Please see data quality assurance statement pertaining to NHSBSA accuracy NHSBSA Data: Data quality assurance

MENTAL HEALTH: Antidepressants: First choice % items (2015)

Section 1: Introduction / Overview		
1.1	**Title**	Antidepressants: First choice % items (2015)
1.2	**MO Theme**	MENTAL HEALTH
1.3	**Definition**	Number of prescription items for Selective Serotonin Re-uptake Inhibitors (SSRIs) (sub-set of BNF 4.3.3) prescribed by approved name as a percentage of the total number of prescription items for 'selected' antidepressants (sub-set of BNF 4.3)
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Number of prescription items for Selective Serotonin Re-uptake Inhibitors (SSRIs) (sub-set of BNF 4.3.3) prescribed by approved name **BNF Name** — **BNF Code** Citalopram HCl — 0403030Z0AA Citalopram Hydrob — 0403030D0AA Escitalopram — 0403030X0AA Fluoxetine HCl — 0403030E0AA Fluvoxamine Mal — 0403030L0AA Paroxetine HCl — 0403030P0AA Sertraline HCl — 0403030Q0AA
1.6	**Denominator**	Number of prescription items for selected antidepressants (sub-set of BNF 4.3) **BNF Name** — **BNF Code** Antidepressant Drugs — 0403 excluding: **BNF Name** — **BNF Code** Amitriptyline Hydrochloride — 0403010B0 Clomipramine Hydrochloride — 0403010F0 Imipramine Hydrochloride — 0403010N0 Nortriptyline — 0403010V0 Trimipramine — 0403010Y0 Monoamine-Oxidase Inhibitors (MAOIs) — 040302 Flupentixol Hydrochloride — 0403040F0 For full details see Medicines Optimisation Key Therapeutic Comparators Descriptions and Specifications on the NHS Digital website – Link in Evidence and Policy base section.
1.7	**Methodology**	Numerator divided by denominator Represented as percentage of items for first choice generic SSRIs (Other time periods and practice level data are available through NHSBSA Information Services Portal: https://apps.nhsbsa.nhs.uk/infosystems/welcome) catalogued under the MOKTT reports
Section 2: Rationale		
2.1	**Purpose**	The purpose of the prescribing comparator is to support the evidence and messages included in the 'Key therapeutic topics – Medicines management options for local implementation' publication by highlighting variation in prescribing across organisations, with the aim of reducing variation and a movement of the mean in the appropriate direction over time. The comparator is intended to support organisations and prescribers in reviewing the appropriateness of current prescribing, revise prescribing where appropriate and monitor implementation.
2.2	**Evidence and Policy Base**	Depression affects people in different ways and can cause a wide variety of symptoms. They range from lasting feelings of sadness and hopelessness, to losing interest in the things patients used to enjoy and feeling very tearful. Many people with depression also have symptoms of anxiety. Depression is quite common and affects about 1 in 10 of us at some point. It affects men and women, young and old. Depression can also strike children. Studies have shown that about 4% of children aged 5 to 16 in the UK are anxious or depressed. Treatment for depression involves either medication or talking treatments, or usually a combination of the two. The prevalence of depression and the devastating symptoms and outcomes it can have for patients, aligned with the NHS resources required to treat depression make it valid for inclusion in this dashboard. Mental Health is also a priority in the NHS England business plan.

		This comparator is taken from the Medicines Optimisation Key Therapeutic Topics (MO KTT) Comparators 2015/16 developed by NHS Digital http://content.digital.nhs.uk/media/18422/Descriptions-and-Specifications-201516/pdf/Descriptions_and_Specifications_2015_16.pdf
Section 3: Data		
3.1	**Data source**	NHS Business Services Authority
3.2	**Data owner & contact details**	nhsbsa.help@nhs.net
3.3	**Time Frame**	Refreshed quarterly with quarterly data Data available from October 2014
3.4	**Data quality assurance**	Please see data quality assurance statement pertaining to NHSBSA accuracy NHSBSA Data: Data quality assurance

MENTAL HEALTH: Depression (DEP003) % achieving upper threshold or above

Section 1: Introduction / Overview		
1.1	**Title**	Depression (DEP003) % achieving upper threshold or above
1.2	**MO Theme**	MENTAL HEALTH
1.3	**Definition**	The percentage of practices in a CCG that achieve upper threshold or above (80% or more inclusive of exceptions) for QOF indicator DEP003
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Number of practices in a CCG that achieve upper threshold or above for QOF indicator DEP003 (achievement of 80% or more inclusive of exceptions)
1.6	**Denominator**	Total number of practices in a CCG with eligible patients for QOF indicator DEP003
1.7	**Methodology**	Numerator divided by denominator Represented as the percentage of practices achieving upper threshold or above inclusive of exceptions The comparator is inclusive of exceptions. In other words, it includes all the patients who satisfy the denominator criteria, even if some have been "excepted". "Exceptions" relate to registered patients who are on the relevant disease register or in the target population group and would ordinarily be included in the indicator denominator, but who are excepted by the contractor on the basis of one or more of the exception criteria. Although patients may be excepted from the denominator, they should still be the recipients of best clinical care and practice. See 2015/16 General Medical Services (GMS) contract Quality and Outcomes Framework (QOF): Guidance for GMS contract 2015/16 (NHS Employers) http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf (page 12 and Section 5 (pages 138 - 145)) for full details.
Section 2: Rationale		
2.1	**Purpose**	The Quality and Outcomes Framework (QOF) rewards contractors for the provision of quality care and helps to standardise improvements in the delivery of primary medical services. Contractor participation in QOF is voluntary. Within the QOF there are a number of indicators that are associated with the effective and/or appropriate use of medicines. NB: For 2015/16 QOF, points are awarded for DEP003 for an achievement of 45 to 80% with a maximum of 10 points awarded for achievement of 80% or more. http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf
2.2	**Evidence and Policy Base**	Depression affects people in different ways and can cause a wide variety of symptoms. They range from lasting feelings of sadness and hopelessness, to losing interest in the things patients used to enjoy and feeling very tearful. Many people with depression also have symptoms of anxiety. Depression is quite common and affects about 1 in 10 of us at some point. It affects men and women, young and old. Depression can also strike children. Studies have shown that about 4% of children aged 5 to 16 in the UK are anxious or depressed. Treatment for depression involves either medication or talking treatments, or usually a combination of the two. The prevalence of depression and the devastating symptoms and outcomes it can have for patients, aligned with the NHS resources required to treat depression make it valid for inclusion in this dashboard. Mental Health is also a priority in the NHS England business plan. This indicator was chosen because existing evidence suggests that many patients with depression remain untreated or treated inappropriately. CCGs with a comparatively higher score may be deploying systematic process to identify and treat patients with depression.
Section 3: Data		
3.1	**Data source**	NHS Digital
3.2	**Data owner & contact details**	QOF CCG level table. NHS Digital website http://qof.digital.nhs.uk/ http://www.content.digital.nhs.uk/catalogue/PUB22266
3.3	**Time Frame**	2015/16 (NB: Refreshed yearly each November with latest annual data) Data available from April 2013
3.4	**Data quality assurance**	None provided

MENTAL HEALTH: Depression (DEP003) % underlying achievement

Section 1: Introduction / Overview		
1.1	**Title**	Depression (DEP003) % underlying achievement
1.2	**MO Theme**	MENTAL HEALTH
1.3	**Definition**	Percentage underlying achievement at CCG level for QOF indicator DEP003 inclusive of exceptions
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Number 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
1.6	**Denominator**	Number of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March inclusive of exceptions
1.7	**Methodology**	Numerator divided by denominator Represented as the percentage underlying achievement level inclusive of exceptions The denominator is inclusive of exceptions. In other words, it includes all the patients who satisfy the denominator criteria, even if some have been "excepted". "Exceptions" relate to registered patients who are on the relevant disease register or in the target population group and would ordinarily be included in the indicator denominator, but who are excepted by the contractor on the basis of one or more of the exception criteria. Although patients may be excepted from the denominator, they should still be the recipients of best clinical care and practice. See 2015/16 General Medical Services (GMS) contract Quality and Outcomes Framework (QOF): Guidance for GMS contract 2015/16 (NHS Employers) http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf (page 12 and Section 5 (pages 138 - 145)) for full details.
Section 2: Rationale		
2.1	**Purpose**	The Quality and Outcomes Framework (QOF) rewards contractors for the provision of quality care and helps to standardise improvements in the delivery of primary medical services. Contractor participation in QOF is voluntary. Within the QOF there are a number of indicators that are associated with the effective and/or appropriate use of medicines. NB: For 2015/16 QOF, points are awarded for DEP003 for an achievement of 45 to 80% with a maximum of 10 points awarded for achievement of 80% or more. http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf
2.2	**Evidence and Policy Base**	Depression affects people in different ways and can cause a wide variety of symptoms. They range from lasting feelings of sadness and hopelessness, to losing interest in the things patients used to enjoy and feeling very tearful. Many people with depression also have symptoms of anxiety. Depression is quite common and affects about 1 in 10 of us at some point. It affects men and women, young and old. Depression can also strike children. Studies have shown that about 4% of children aged 5 to 16 in the UK are anxious or depressed. Treatment for depression involves either medication or talking treatments, or usually a combination of the two. The prevalence of depression and the devastating symptoms and outcomes it can have for patients, aligned with the NHS resources required to treat depression make it valid for inclusion in this dashboard. Mental Health is also a priority in the NHS England business plan. This indicator was chosen because existing evidence suggests that many patients with depression remain untreated or treated inappropriately. CCGs with a comparatively higher score may be deploying systematic process to identify and treat patients with depression.
Section 3: Data		
3.1	**Data source**	NHS Digital
3.2	**Data owner & contact details**	QOF CCG level table. NHS Digital website http://qof.digital.nhs.uk/ http://www.content.digital.nhs.uk/catalogue/PUB22266
3.3	**Time Frame**	2015/16 (NB: Refreshed yearly each November with latest annual data) Data available from April 2013
3.4	**Data quality assurance**	None provided

MENTAL HEALTH: Hypnotics: ADQ/STAR PU (ADQ based)

Section 1: Introduction / Overview		
1.1	**Title**	Hypnotics: ADQ/STAR PU (ADQ based)
1.2	**MO Theme**	MENTAL HEALTH
1.3	**Definition**	Number of average daily quantities (ADQs) for benzodiazepines (indicated for use as hypnotics) and "Z" drugs per hypnotics (BNF 4.1.1 sub-set) ADQ based STAR-PU
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Total average daily quantity (ADQ) usage for benzodiazepines and "Z" drugs (zolpidem, zopiclone and zaleplon) in BNF 4.1.1 **BNF Name** — **BNF Code** Flunitrazepam — 0401010I0 Flurazepam Hydrochloride — 0401010L0 Loprazolam Mesilate — 0401010N0 Lormetazepam — 0401010P0 Nitrazepam — 0401010R0 Temazepam — 0401010T0 Triazolam — 0401010V0 Zaleplon — 0401010W0 Zolpidem Tartrate — 0401010Y0 Zopiclone — 0401010Z0
1.6	**Denominator**	Total number of hypnotics (BNF 4.1.1 sub-set) ADQ based STAR-PU **Hypnotics (BNF 4.1.1 sub-set) ADQ based STAR-PU (2013 weighting)** **Age Band** — **Male** — **Female** 0 to 4 — 0.0 — 0.0 5 to 14 — 0.0 — 0.0 15 to 24 — 0.1 — 0.2 25 to 34 — 0.6 — 0.9 35 to 44 — 1.6 — 1.9 45 to 54 — 2.4 — 3.6 55 to 64 — 3.0 — 5.0 65 to 74 — 4.4 — 7.6 75+ — 6.7 — 11.9
1.7	**Methodology**	Numerator divided by denominator Represented as hypnotics ADQ / STAR-PU STAR-PUs are weightings devised by NHS Digital and the following link provides further information regarding Prescribing Measures http://content.digital.nhs.uk/media/10027/Prescribing-measures-booklet/pdf/pres-meas-book-v7.pdf NHSBSA update list size information throughout a financial quarter and these patient list sizes are only fully refreshed at the end of that financial quarter; therefore STAR-PU values used in this comparator are based on the latest available complete patient list size. (Other time periods and practice level data are available through NHSBSA Information Services Portal: https://apps.nhsbsa.nhs.uk/infosystems/welcome) catalogued under the MOKTT reports
Section 2: Rationale		
2.1	**Purpose**	The purpose of the prescribing comparator is to support the evidence and messages included in the 'Key therapeutic topics – Medicines management options for local implementation' publication by highlighting variation in prescribing across organisations, with the aim of reducing variation and a movement of the mean in the appropriate direction over time. The comparator is intended to support organisations and prescribers in reviewing the appropriateness of current prescribing, revise prescribing where appropriate and monitor implementation. This indicator helps review the number of hypnotics used within a given population.
2.2	**Evidence and Policy Base**	Hypnotics are medications that encourage sleep. They may be considered: •if insomnia symptoms are very severe

		•to help ease short-term insomnia •if the good sleep hygiene and cognitive and behavioural treatments mentioned above prove ineffective More recently evidence has come to light that overuse of these medicines may lead to dependency and do more harm than good. It is generally considered good practice to treat the underlying cause of insomnia rather than the symptoms. This comparator is taken from the Medicines Optimisation Key Therapeutic Topics (MO KTT) Comparators 2015/16 developed by NHS Digital http://content.digital.nhs.uk/media/18422/Descriptions-and-Specifications-201516/pdf/Descriptions_and_Specifications_2015_16.pdf
Section 3: Data		
3.1	**Data source**	NHS Business Services Authority
3.2	**Data owner & contact details**	nhsbsa.help@nhs.net
3.3	**Time Frame**	Refreshed quarterly with quarterly data Data available from October 2014
3.4	**Data quality assurance**	Please see data quality assurance statement pertaining to NHSBSA accuracy NHSBSA Data: Data quality assurance

MENTAL HEALTH: Mental Health (MH010) % achieving upper threshold or above

Section 1: Introduction / Overview		
1.1	**Title**	Mental Health (MH010) % achieving upper threshold or above
1.2	**MO Theme**	MENTAL HEALTH
1.3	**Definition**	The percentage of practices in a CCG that achieve upper threshold or above (90% or more inclusive of exceptions) for QOF indicator MH010
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Number of practices in a CCG that achieve upper threshold or above for QOF indicator MH010 (achievement of 90% or more inclusive of exceptions)
1.6	**Denominator**	Total number of practices in a CCG with eligible patients for QOF indicator MH010
1.7	**Methodology**	Numerator divided by denominator Represented as the percentage of practices achieving upper threshold or above The comparator is inclusive of exceptions. In other words, it includes all the patients who satisfy the denominator criteria, even if some have been "excepted". "Exceptions" relate to registered patients who are on the relevant disease register or in the target population group and would ordinarily be included in the indicator denominator, but who are excepted by the contractor on the basis of one or more of the exception criteria. Although patients may be excepted from the denominator, they should still be the recipients of best clinical care and practice. See 2015/16 General Medical Services (GMS) contract Quality and Outcomes Framework (QOF): Guidance for GMS contract 2015/16 (NHS Employers) http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf (page 12 and Section 5 (pages 138 - 145)) for full details.
Section 2: Rationale		
2.1	**Purpose**	The Quality and Outcomes Framework (QOF) rewards contractors for the provision of quality care and helps to standardise improvements in the delivery of primary medical services. Contractor participation in QOF is voluntary. Within the QOF there are a number of indicators that are associated with the effective and/or appropriate use of medicines. NB: For 2015/16 QOF, points are awarded for MH010 for an achievement of 50 to 90% with a maximum of 2 points awarded for achievement of 90% or more. http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf
2.2	**Evidence and Policy Base**	Lithium monitoring is essential due to the narrow therapeutic range of serum lithium and the potential toxicity from intercurrent illness, declining renal function or co-prescription of drugs, for example thiazide diuretics or non-steroidal anti-inflammatory drugs (NSAIDS), which may reduce lithium excretion This particular indicator was chosen as a proxy marker to demonstrate good adherence to medication regimes. The assumption is that in order to stay within therapeutic range, the prescriber, patient and pharmacist must work collaboratively to support the patients to achieve this aim. The higher the proportion of patients who are within range could indicate a CCG with good practices in place.
Section 3: Data		
3.1	**Data source**	NHS Digital
3.2	**Data owner & contact details**	QOF CCG level table. NHS Digital website http://qof.digital.nhs.uk/ http://www.content.digital.nhs.uk/catalogue/PUB22266
3.3	**Time Frame**	2015/16 (NB: Refreshed yearly each November with latest annual data) Data available from April 2013
3.4	**Data quality assurance**	None provided

MENTAL HEALTH: Mental Health (MH010) % underlying achievement

Section 1: Introduction / Overview		
1.1	**Title**	Mental Health (MH010) % underlying achievement
1.2	**MO Theme**	MENTAL HEALTH
1.3	**Definition**	Percentage underlying achievement at CCG level for QOF indicator MH010 inclusive of exceptions
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Number of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months
1.6	**Denominator**	Number of patients on lithium therapy inclusive of exceptions
1.7	**Methodology**	Numerator divided by denominator Represented as the percentage underlying achievement level inclusive of exceptions The denominator is inclusive of exceptions. In other words, it includes all the patients who satisfy the denominator criteria, even if some have been "excepted". "Exceptions" relate to registered patients who are on the relevant disease register or in the target population group and would ordinarily be included in the indicator denominator, but who are excepted by the contractor on the basis of one or more of the exception criteria. Although patients may be excepted from the denominator, they should still be the recipients of best clinical care and practice. See 2015/16 General Medical Services (GMS) contract Quality and Outcomes Framework (QOF): Guidance for GMS contract 2015/16 (NHS Employers) http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf (page 12 and Section 5 (pages 138 - 145)) for full details.
Section 2: Rationale		
2.1	**Purpose**	The Quality and Outcomes Framework (QOF) rewards contractors for the provision of quality care and helps to standardise improvements in the delivery of primary medical services. Contractor participation in QOF is voluntary. Within the QOF there are a number of indicators that are associated with the effective and/or appropriate use of medicines. NB: For 2015/16 QOF, points are awarded for MH010 for an achievement of 50 to 90% with a maximum of 2 points awarded for achievement of 90% or more. http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf
2.2	**Evidence and Policy Base**	Lithium monitoring is essential due to the narrow therapeutic range of serum lithium and the potential toxicity from intercurrent illness, declining renal function or co-prescription of drugs, for example thiazide diuretics or non-steroidal anti-inflammatory drugs (NSAIDS), which may reduce lithium excretion This particular indicator was chosen as a proxy marker to demonstrate good adherence to medication regimes. The assumption is that in order to stay within therapeutic range, the prescriber, patient and pharmacist must work collaboratively to support the patients to achieve this aim. The higher the proportion of patients who are within range could indicate a CCG with good practices in place.
Section 3: Data		
3.1	**Data source**	NHS Digital
3.2	**Data owner & contact details**	QOF CCG level table. NHS Digital website http://qof.digital.nhs.uk/ http://www.content.digital.nhs.uk/catalogue/PUB22266
3.3	**Time Frame**	2015/16 (NB: Refreshed yearly each November with latest annual data) Data available from April 2013
3.4	**Data quality assurance**	None provided

OSTEOPOROSIS: Osteoporosis (OST005) % achieving upper threshold or above

Section 1: Introduction / Overview		
1.1	**Title**	Osteoporosis (OST005) % achieving upper threshold or above
1.2	**MO Theme**	OSTEOPOROSIS
1.3	**Definition**	The percentage of practices in a CCG that achieve upper threshold or above (60% or more inclusive of exceptions) for QOF indicator OST005
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Number of practices in a CCG that achieve upper threshold or above for QOF indicator OST005 (achievement of 60% or more inclusive of exceptions)
1.6	**Denominator**	Total number of practices in a CCG with eligible patients for QOF indicator OST005
1.7	**Methodology**	Numerator divided by denominator Represented as the percentage of practices achieving upper threshold or above inclusive of exceptions The comparator is inclusive of exceptions. In other words, it includes all the patients who satisfy the denominator criteria, even if some have been "excepted". "Exceptions" relate to registered patients who are on the relevant disease register or in the target population group and would ordinarily be included in the indicator denominator, but who are excepted by the contractor on the basis of one or more of the exception criteria. Although patients may be excepted from the denominator, they should still be the recipients of best clinical care and practice. See 2015/16 General Medical Services (GMS) contract Quality and Outcomes Framework (QOF): Guidance for GMS contract 2015/16 (NHS Employers) http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf (page 12 and Section 5 (pages 138 - 145)) for full details.
Section 2: Rationale		
2.1	**Purpose**	The Quality and Outcomes Framework (QOF) rewards contractors for the provision of quality care and helps to standardise improvements in the delivery of primary medical services. Contractor participation in QOF is voluntary. Within the QOF there are a number of indicators that are associated with the effective and/or appropriate use of medicines. NB: For 2015/15 QOF, points are awarded for OST005 for an achievement of 30 to 60% with a maximum of 3 points awarded for achievement of 60% or more. http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf
2.2	**Evidence and Policy Base**	Interventions for secondary prevention of fractures in patients who have had an osteoporotic fragility fracture include pharmacological intervention.
Section 3: Data		
3.1	**Data source**	NHS Digital
3.2	**Data owner & contact details**	QOF CCG level table. NHS Digital website http://qof.digital.nhs.uk/ http://www.content.digital.nhs.uk/catalogue/PUB22266
3.3	**Time Frame**	2015/16 (NB: Refreshed yearly each November with latest annual data) Data available from April 2013
3.4	**Data quality assurance**	None provided

OSTEOPOROSIS: Osteoporosis (OST005) % underlying achievement

Section 1: Introduction / Overview		

1.1	**Title**	Osteoporosis (OST005) % underlying achievement
1.2	**MO Theme**	OSTEOPOROSIS
1.3	**Definition**	Percentage underlying achievement at CCG level for QOF indicator OST005 inclusive of exceptions
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Number 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
1.6	**Denominator**	Number of patients aged 75 or over with a record of a fragility fracture on or after 1 April 2014 and a diagnosis of osteoporosis inclusive of exceptions
1.7	**Methodology**	Numerator divided by denominator Represented as the percentage underlying achievement level inclusive of exceptions The denominator is inclusive of exceptions. In other words, it includes all the patients who satisfy the denominator criteria, even if some have been "excepted". "Exceptions" relate to registered patients who are on the relevant disease register or in the target population group and would ordinarily be included in the indicator denominator, but who are excepted by the contractor on the basis of one or more of the exception criteria. Although patients may be excepted from the denominator, they should still be the recipients of best clinical care and practice. See 2015/16 General Medical Services (GMS) contract Quality and Outcomes Framework (QOF): Guidance for GMS contract 2015/16 (NHS Employers) http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf (page 12 and Section 5 (pages 138 - 145)) for full details.
Section 2: Rationale		
2.1	**Purpose**	The Quality and Outcomes Framework (QOF) rewards contractors for the provision of quality care and helps to standardise improvements in the delivery of primary medical services. Contractor participation in QOF is voluntary. Within the QOF there are a number of indicators that are associated with the effective and/or appropriate use of medicines. NB: For 2015/15 QOF, points are awarded for OST005 for an achievement of 30 to 60% with a maximum of 3 points awarded for achievement of 60% or more. http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf
2.2	**Evidence and Policy Base**	Interventions for secondary prevention of fractures in patients who have had an osteoporotic fragility fracture include pharmacological intervention.
Section 3: Data		
3.1	**Data source**	NHS Digital
3.2	**Data owner & contact details**	QOF CCG level table. NHS Digital website http://qof.digital.nhs.uk/ http://www.content.digital.nhs.uk/catalogue/PUB22266
3.3	**Time Frame**	2015/16 (NB: Refreshed yearly each November with latest annual data) Data available from April 2013
3.4	**Data quality assurance**	None provided

PATIENT EXPERIENCE: Awareness of the on-line ordering of repeat prescriptions service

Section 1: Introduction / Overview

1.1	**Title**	Awareness of the on-line ordering of repeat prescriptions service
1.2	**MO Theme**	PATIENT EXPERIENCE
1.3	**Definition**	Percentage of patients who responded to the section “Awareness of online services offered by GP surgery” who were aware of the on-line repeat prescription ordering service offered by their GP practice
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Number of patients aware of on-line repeat prescription ordering service
1.6	**Denominator**	Number of patients who responded to the section “Awareness of online services offered by GP surgery”
1.7	**Methodology**	Numerator divided by denominator Represented as the percentage of patients aware of on-line repeat prescription ordering service Responses include all those completing a questionnaire Results of the survey are weighted. For further details see: https://gp-patient.co.uk/faq/weighted-data  Jul-Sept+2015+GP+ Patient+Survey+que The following document is a PDF version of the GP Patient Survey
Section 2: Rationale		
2.1	**Purpose**	A measure of patient awareness to an on-line service for ordering repeat prescriptions provided by their GP.
2.2	**Evidence and Policy Base**	An evaluation was undertaken by Monmouth Partners to provide NHS England with a better understanding of the value of its Medicines Optimisation (MO) Dashboard to patients. A recommendation from the evaluation was ‘Patient experience data for medicines is being collated nationally and should be included in the current MO Dashboard for NHS stakeholders. ‘*Understanding the patient experience*’ is the first principle of medicines optimisation and this should be echoed through future reiterations of the MO Dashboard’ . The NHS’s ambition is to embrace technology as part of its drive to offer modern, convenient and responsive services to patients, their families and carers. GP practices are leading the way. Today, the majority of GP practices already offer online services, including appointment booking, ordering of repeat prescription, and access to summary information in records. GP practices will increasingly expand online services over the next year. By April 2016, online patient records should include coded information on medication, allergies, illnesses, immunisations and test results. Patients have been telling NHS England that they are ready and want to take more control of their own health and wellbeing. Digital technology has the power to change the relationship between patients and their GP practice. On-line ordering of repeat prescriptions is safer, more efficient and more convenient to patients and also services https://www.england.nhs.uk/ourwork/pe/patient-online/ https://www.england.nhs.uk/wp-content/uploads/2015/11/po-support-resources-guide.pdf
Section 3: Data		
3.1	**Data source**	NHS England https://gp-patient.co.uk/surveys-and-reports#july-2016
3.2	**Data owner & contact details**	https://gp-patient.co.uk/
3.3	**Time Frame**	Refreshed periodically with 6 months of survey being undertaken. Data available from July 2015
3.4	**Data quality assurance**	See GP Survey – Technical annex http://gp-survey-production.s3.amazonaws.com/archive/2016/July/July2016NationalTechnicalReport.pdf

PATIENT EXPERIENCE: Use of the on-line ordering of repeat prescriptions service

Section 1: Introduction / Overview		
1.1	**Title**	Use of the on-line ordering of repeat prescriptions service
1.2	**MO Theme**	PATIENT EXPERIENCE
1.3	**Definition**	Percentage of patients who responded to the section "Use of online services offered by GP surgery" who in the reporting period used the on-line repeat prescription ordering service offered by their GP practice
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Number of patients who used the on-line repeat prescription ordering service in the reporting period
1.6	**Denominator**	Number of patients who responded to the section "Use of on-line services offered by GP surgery"
1.7	**Methodology**	Numerator divided by denominator Represented as the percentage of patients using on-line repeat prescription ordering service Responses include all those completing a questionnaire Results of the survey are weighted. For further details see: https://gp-patient.co.uk/faq/weighted-data The following document is a PDF version of the GP Patient Survey  Jul-Sept+2015+GP+ Patient+Survey+que
Section 2: Rationale		
2.1	**Purpose**	A measure of patient use of on-line services for ordering repeat prescriptions provided by their GP.
2.2	**Evidence and Policy Base**	An evaluation was undertaken by Monmouth Partners to provide NHS England with a better understanding of the value of its Medicines Optimisation (MO) Dashboard to patients. A recommendation from the evaluation was 'Patient experience data for medicines is being collated nationally and should be included in the current MO Dashboard for NHS stakeholders. '*Understanding the patient experience*' is the first principle of medicines optimisation and this should be echoed through future reiterations of the MO Dashboard' . The NHS's ambition is to embrace technology as part of its drive to offer modern, convenient and responsive services to patients, their families and carers. GP practices are leading the way. Today, the majority of GP practices already offer online services, including appointment booking, ordering of repeat prescription, and access to summary information in records. GP practices will increasingly expand online services over the next year. By April 2016, online patient records should include coded information on medication, allergies, illnesses, immunisations and test results. Patients have been telling NHS England that they are ready and want to take more control of their own health and wellbeing. Digital technology has the power to change the relationship between patients and their GP practice. On-line ordering of repeat prescriptions is safer, more efficient and more convenient to patients and also services https://www.england.nhs.uk/ourwork/pe/patient-online/ https://www.england.nhs.uk/wp-content/uploads/2015/11/po-support-resources-guide.pdf
Section 3: Data		
3.1	**Data source**	NHS England https://gp-patient.co.uk/surveys-and-reports#july-2016

3.2	**Data owner & contact details**	https://gp-patient.co.uk/
3.3	**Time Frame**	Refreshed periodically with 6 months of survey being undertaken Data available from July 2015
3.4	**Data quality assurance**	See GP Survey – Technical annex http://gp-survey-production.s3.amazonaws.com/archive/2016/July/July2016NationalTechnicalReport.pdf

PATIENT SAFETY: Summary Care Records Availability

Section 1: Introduction / Overview		
1.1	**Title**	Summary Care Records Availability
1.2	**MO Theme**	PATIENT SAFETY
1.3	**Definition**	Proportion of practices who are live with the Summary Care Record (SCR) and therefore able to upload patient records onto the SCR
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Number of Practices live with the SCR
1.6	**Denominator**	Total number of practices
1.7	**Methodology**	Numerator divided by denominator Represented as the percentage of practices live with the SCR
Section 2: Rationale		
2.1	**Purpose**	Allow for the uploading of Summary Care Records by Practices to facilitate safe and effective medicines optimisation in other care settings
2.2	**Evidence and Policy Base**	SCRs have many benefits for patients and healthcare staff in urgent and emergency care settings (such as out-of-hours GP services and Emergency Departments). SCRs provide access to health information that has previously been unavailable, enabling authorised healthcare staff to make informed clinical decisions. Benefits to patients • SCRs are accessible to authorised healthcare staff treating patients in an emergency in England. This will be particularly useful when a patient cannot give information (for example if they are unconscious) or when they are away from home and are unable to see their own GP. • Patient care can be supported by healthcare staff having faster access to their medical information and patients may not be required to repeat information to different NHS staff treating them. For example, in a hospital setting, healthcare staff will be able to access a patient's SCRs immediately enabling faster assessment. • SCRs can support better, safer prescribing of medication for patients by providing up to date information on a patient's allergies, previous adverse reactions and medications. • SCRs will enable vulnerable patient groups and those patients that are unable to communicate well with healthcare staff. For example, a non-English speaking patient that could struggle to communicate their condition would no longer be disadvantaged as their SCR would be available to the treating clinician. • Additional information, such as end of life care plans and relevant diagnoses, may be available to inform clinical care where it is appropriate. Benefits to NHS healthcare staff • Important patient information will be available to authorised healthcare staff treating patients in an emergency where they had previously not had access to it. This will be particularly useful to NHS staff treating patients in an emergency, when a patient needs treatment out of hours or away from their local area. • SCRs contain details of a patient's key health information including medications, allergies and adverse reactions. This enables clinicians to feel more confident to treat patients. • Medicines reconciliation (where a patient's prescribed medication is checked against current medications to ensure there is no conflict) will become more efficient in hospital pharmacies as pharmacists will be able to immediately refer to the SCR in order to reconcile the medications prescribed to the patient. Further information on the SCR is available on the NHS Digital website.
Section 3: Data		
3.1	**Data source**	NHS Digital
3.2	**Data owner & contact details**	http://digital.nhs.uk http://systems.digital.nhs.uk/scr
3.3	**Time Frame**	Refreshed quarterly with most up to date data available Data available from as at 17 April 2015
3.4	**Data quality assurance**	Summary Care Record has their own internal quality process to assure the data they receive from various sources that contributes to SCR availability at CCG level. Best endeavours are made to ensure this data is accurate but due to the complex nature there may be some errors at times.

RESPIRATORY: Asthma (AST003) % achieving upper threshold or above

Section 1: Introduction / Overview		
1.1	**Title**	Asthma (AST003) % achieving upper threshold or above
1.2	**MO Theme**	RESPIRATORY
1.3	**Definition**	The percentage of practices in a CCG that achieve upper threshold or above (70% or more inclusive of exceptions) for QOF indicator AST003
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Number of practices in a CCG that achieve upper threshold or above for QOF indicator AST003 (achievement of 70% or more inclusive of exceptions)
1.6	**Denominator**	Total number of practices in a CCG with eligible patients for QOF indicator AST003
1.7	**Methodology**	Numerator divided by denominator Represented as the percentage of practices achieving upper threshold or above inclusive of exceptions The comparator is inclusive of exceptions. In other words, it includes all the patients who satisfy the denominator criteria, even if some have been "excepted". "Exceptions" relate to registered patients who are on the relevant disease register or in the target population group and would ordinarily be included in the indicator denominator, but who are excepted by the contractor on the basis of one or more of the exception criteria. Although patients may be excepted from the denominator, they should still be the recipients of best clinical care and practice. See 2015/16 General Medical Services (GMS) contract Quality and Outcomes Framework (QOF): Guidance for GMS contract 2015/16 (NHS Employers) http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf (page 12 and Section 5 (pages 138 - 145)) for full details.
Section 2: Rationale		
2.1	**Purpose**	The Quality and Outcomes Framework (QOF) rewards contractors for the provision of quality care and helps to standardise improvements in the delivery of primary medical services. Contractor participation in QOF is voluntary. Within the QOF there are a number of indicators that are associated with the effective and/or appropriate use of medicines. NB: For 2015/16 QOF, points are awarded for AST003 for an achievement of 45 to 70% with a maximum of 20 points awarded for achievement of 70% or more. http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf
2.2	**Evidence and Policy Base**	Asthma is a common long-term condition that can cause coughing, wheezing, chest tightness and breathlessness. The severity of these symptoms varies from person to person. Asthma can be controlled well in most people most of the time, although some people may have more persistent problems. Occasionally, asthma symptoms can get gradually or suddenly worse. While there is no cure for asthma, there are a number of treatments that can help control the condition. Treatment is based on two important goals, which are: •relieving symptoms •preventing future symptoms and attacks For most people, treatment will involve the occasional – or, more commonly, daily – use of medications, usually taken using an inhaler. However, identifying and avoiding possible triggers is also important. Severe attacks may require hospital treatment and can be life threatening, although this is unusual. Appropriate treatment in terms of prevention and alleviation of symptoms is critical to avoid emergency admissions and enhanced quality of life, hence its inclusion in this dashboard. This indicator was chosen because existing evidence suggests that many patients with asthma remain untreated or treated inappropriately. CCGs with a comparatively higher score may be deploying systematic process to identify and treat patients with asthma.

Section 3: Data		
3.1	**Data source**	NHS Digital
3.2	**Data owner & contact details**	QOF CCG level table. NHS Digital website http://qof.digital.nhs.uk/ http://www.content.digital.nhs.uk/catalogue/PUB22266
3.3	**Time Frame**	2015/16 (NB: Refreshed yearly each November with latest annual data) Data available from April 2013
3.4	**Data quality assurance**	None provided

RESPIRATORY: Asthma (AST003) % underlying achievement

Section 1: Introduction / Overview		
1.1	**Title**	Asthma (AST003) % underlying achievement
1.2	**MO Theme**	RESPIRATORY
1.3	**Definition**	Percentage underlying achievement at CCG level for QOF indicator AST003 inclusive of exceptions
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Number 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
1.6	**Denominator**	Number of patients with asthma on the register inclusive of exceptions
1.7	**Methodology**	Numerator divided by denominator Represented as the percentage underlying achievement level inclusive of exceptions The denominator is inclusive of exceptions. In other words, it includes all the patients who satisfy the denominator criteria, even if some have been "excepted". "Exceptions" relate to registered patients who are on the relevant disease register or in the target population group and would ordinarily be included in the indicator denominator, but who are excepted by the contractor on the basis of one or more of the exception criteria. Although patients may be excepted from the denominator, they should still be the recipients of best clinical care and practice. See 2015/16 General Medical Services (GMS) contract Quality and Outcomes Framework (QOF): Guidance for GMS contract 2015/16 (NHS Employers) http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf (page 12 and Section 5 (pages 138 - 145)) for full details.
Section 2: Rationale		
2.1	**Purpose**	The Quality and Outcomes Framework (QOF) rewards contractors for the provision of quality care and helps to standardise improvements in the delivery of primary medical services. Contractor participation in QOF is voluntary. Within the QOF there are a number of indicators that are associated with the effective and/or appropriate use of medicines. NB: For 2015/16 QOF, points are awarded for AST003 for an achievement of 45 to 70% with a maximum of 20 points awarded for achievement of 70% or more. http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf
2.2	**Evidence and Policy Base**	Asthma is a common long-term condition that can cause coughing, wheezing, chest tightness and breathlessness. The severity of these symptoms varies from person to person. Asthma can be controlled well in most people most of the time, although some people may have more persistent problems. Occasionally, asthma symptoms can get gradually or suddenly worse. While there is no cure for asthma, there are a number of treatments that can help control the condition. Treatment is based on two important goals, which are: •relieving symptoms •preventing future symptoms and attacks For most people, treatment will involve the occasional – or, more commonly, daily – use of medications, usually taken using an inhaler. However, identifying and avoiding possible triggers is also important. Severe attacks may require hospital treatment and can be life threatening, although this is unusual. Appropriate treatment in terms of prevention and alleviation of symptoms is critical to avoid emergency admissions and enhanced quality of life, hence its inclusion in this dashboard.
Section 3: Data		
3.1	**Data source**	NHS Digital
3.2	**Data owner & contact details**	QOF CCG level table. NHS Digital website http://qof.digital.nhs.uk/ http://www.content.digital.nhs.uk/catalogue/PUB22266
3.3	**Time Frame**	2015/16 (NB: Refreshed yearly each November with latest annual data) Data available from April 2013
3.4	**Data quality assurance**	None provided

RESPIRATORY: Emergency Asthma Admissions

Section 1: Introduction / Overview		
1.1	**Title**	Emergency Asthma Admissions
1.2	**MO Theme**	RESPIRATORY
1.3	**Definition**	The number of emergency attendances for asthma per 100 patients on the practice asthma disease register
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Count of completed spells and sum of PBR tariff where a) admission method is emergency (21, 22, 23, 24, 28); b) patient classification is inpatient (1); c) ICD10 primary diagnosis code is in range J45- J46
1.6	**Denominator**	Number of patients on practice disease register for asthma as of 31 March 2015
1.7	**Methodology**	Numerator divided by denominator Represented as emergency asthma admissions per 100 patients on asthma disease register
Section 2: Rationale		
2.1	**Purpose**	To highlight and compare the rate of hospital emergency admissions due to complications associated with asthma as a proxy for the effective management of the condition.
2.2	**Evidence and Policy Base**	Asthma is a common long-term condition that can cause coughing, wheezing, chest tightness and breathlessness. The severity of these symptoms varies from person to person. Asthma can be controlled well in most people most of the time, although some people may have more persistent problems. Occasionally, asthma symptoms can get gradually or suddenly worse. While there is no cure for asthma, there are a number of treatments that can help control the condition. Treatment is based on two important goals, which are: •relieving symptoms •preventing future symptoms and attacks For most people, treatment will involve the occasional – or, more commonly, daily – use of medications, usually taken using an inhaler. However, identifying and avoiding possible triggers is also important. Severe attacks may require hospital treatment and can be life threatening, although this is unusual. Appropriate treatment in terms of prevention and alleviation of symptoms is critical to avoid emergency admissions and enhanced quality of life, hence its inclusion in this dashboard. Emergency admissions due to asthma can often be avoidable if prevention and alleviation of symptoms are managed effectively and appropriately. Emergency admissions due to asthma can therefore be used to an extent as a proxy for the quality of management of the condition, including the optimal use of medicines.
Section 3: Data		
3.1	**Data source**	NHS England General Practice High Level Indicators https://www.primarycare.nhs.uk/
3.2	**Data owner & contact details**	NHS England General Practice High Level Indicators https://www.primarycare.nhs.uk/
3.3	**Time Frame**	Refreshed periodically with 12 months accumulated data Data available from April 2013
3.4	**Data quality assurance**	None provided

RESPIRATORY: Chronic Obstructive Pulmonary Disease (COPD003) % achieving upper threshold or above

Section 1: Introduction / Overview		
1.1	**Title**	Chronic Obstructive Pulmonary Disease (COPD003) % achieving upper threshold or above
1.2	**MO Theme**	RESPIRATORY
1.3	**Definition**	The percentage of practices in a CCG that achieve upper threshold or above (90% or more inclusive of exceptions) for QOF indicator COPD003
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Number of practices in a CCG that achieve upper threshold or above for QOF indicator COPD003 (achievement of 90% or more inclusive of exceptions)
1.6	**Denominator**	Total number of practices in a CCG with eligible patients for QOF indicator COPD003
1.7	**Methodology**	Numerator divided by denominator Represented as the percentage of practices achieving upper threshold or above inclusive of exceptions The comparator is inclusive of exceptions. In other words, it includes all the patients who satisfy the denominator criteria, even if some have been "excepted". "Exceptions" relate to registered patients who are on the relevant disease register or in the target population group and would ordinarily be included in the indicator denominator, but who are excepted by the contractor on the basis of one or more of the exception criteria. Although patients may be excepted from the denominator, they should still be the recipients of best clinical care and practice. See 2015/16 General Medical Services (GMS) contract Quality and Outcomes Framework (QOF): Guidance for GMS contract 2015/16 (NHS Employers) http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf (page 12 and Section 5 (pages 138 - 145)) for full details.
Section 2: Rationale		
2.1	**Purpose**	The Quality and Outcomes Framework (QOF) rewards contractors for the provision of quality care and helps to standardise improvements in the delivery of primary medical services. Contractor participation in QOF is voluntary. Within the QOF there are a number of indicators that are associated with the effective and/or appropriate use of medicines. NB: For 2015/16 QOF, points are awarded for COPD003 for an achievement of 50 to 90% with a maximum of 9 points awarded for achievement of 90% or more. http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf
2.2	**Evidence and Policy Base**	COPD is one of the most common respiratory diseases in the UK. It usually only starts to affect people over the age of 35, although most people are not diagnosed until they are in their 50s. It is thought there are more than 3 million people living with the disease in the UK, of which only about 900,000 have been diagnosed. This is because many people who develop symptoms of COPD do not get medical help because they often dismiss their symptoms as a 'smoker's cough'. COPD affects more men than women, although rates in women are increasing. Good treatment of COPD can make a dramatic difference to quality of life and reduce emergency hospital admissions. Appropriate treatment in terms of prevention and alleviation of symptoms is critical to avoid emergency admissions and enhanced quality of life, hence its inclusion in this dashboard. This indicator was chosen because existing evidence suggests that many patients with COPD remain untreated or treated inappropriately. CCGs with a comparatively higher score may be deploying systematic process to identify and treat patients with COPD.
Section 3: Data		
3.1	**Data source**	NHS Digital
3.2	**Data owner & contact details**	QOF CCG level table. NHS Digital website http://qof.digital.nhs.uk/ http://www.content.digital.nhs.uk/catalogue/PUB22266
3.3	**Time Frame**	2015/16 (NB: Refreshed yearly each November with latest annual data) Data available from April 2013
3.4	**Data quality assurance**	None provided

RESPIRATORY: Chronic Obstructive Pulmonary Disease (COPD003) % underlying achievement

Section 1: Introduction / Overview		
1.1	**Title**	Chronic Obstructive Pulmonary Disease (COPD003) % underlying achievement
1.2	**MO Theme**	RESPIRATORY
1.3	**Definition**	Percentage underlying achievement at CCG level for QOF indicator COPD003 inclusive of exceptions
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Number 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
1.6	**Denominator**	Number of patients with COPD inclusive of exceptions
1.7	**Methodology**	Numerator divided by denominator Represented as the percentage underlying achievement level inclusive of exceptions The denominator is inclusive of exceptions. In other words, it includes all the patients who satisfy the denominator criteria, even if some have been "excepted". "Exceptions" relate to registered patients who are on the relevant disease register or in the target population group and would ordinarily be included in the indicator denominator, but who are excepted by the contractor on the basis of one or more of the exception criteria. Although patients may be excepted from the denominator, they should still be the recipients of best clinical care and practice. See 2015/16 General Medical Services (GMS) contract Quality and Outcomes Framework (QOF): Guidance for GMS contract 2015/16 (NHS Employers) http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf (page 12 and Section 5 (pages 138 - 145)) for full details.
Section 2: Rationale		
2.1	**Purpose**	The Quality and Outcomes Framework (QOF) rewards contractors for the provision of quality care and helps to standardise improvements in the delivery of primary medical services. Contractor participation in QOF is voluntary. Within the QOF there are a number of indicators that are associated with the effective and/or appropriate use of medicines. NB: For 2015/16 QOF, points are awarded for COPD003 for an achievement of 50 to 90% with a maximum of 9 points awarded for achievement of 90% or more. http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2015%20-%2016/2015-16%20QOF%20guidance%20documents.pdf
2.2	**Evidence and Policy Base**	COPD is one of the most common respiratory diseases in the UK. It usually only starts to affect people over the age of 35, although most people are not diagnosed until they are in their 50s. It is thought there are more than 3 million people living with the disease in the UK, of which only about 900,000 have been diagnosed. This is because many people who develop symptoms of COPD do not get medical help because they often dismiss their symptoms as a 'smoker's cough'. COPD affects more men than women, although rates in women are increasing. Good treatment of COPD can make a dramatic difference to quality of life and reduce emergency hospital admissions. Appropriate treatment in terms of prevention and alleviation of symptoms is critical to avoid emergency admissions and enhanced quality of life, hence its inclusion in this dashboard. This indicator was chosen because existing evidence suggests that many patients with COPD remain untreated or treated inappropriately. CCGs with a comparatively higher score may be deploying systematic process to identify and treat patients with COPD.
Section 3: Data		
3.1	**Data source**	NHS Digital
3.2	**Data owner & contact details**	QOF CCG level table. NHS Digital website http://qof.digital.nhs.uk/ http://www.content.digital.nhs.uk/catalogue/PUB22266
3.3	**Time Frame**	2015/16 (NB: Refreshed yearly each November with latest annual data) Data available from April 2013
3.4	**Data quality assurance**	None provided

RESPIRATORY: Emergency COPD Admissions

Section 1: Introduction / Overview		
1.1	**Title**	Emergency COPD Admissions
1.2	**MO Theme**	RESPIRATORY
1.3	**Definition**	The number of emergency attendances for chronic obstructive pulmonary disease per 100 patients on the practice COPD disease register
1.4	**Reporting Level**	CCG level (aggregated to Area, Local Office, AHSN, STP, Similar 10 CCGs, CCG demographic cluster, Region and England)
1.5	**Numerator**	Count of completed spells and sum of PBR tariff where a) admission method is emergency (21, 22, 23, 24, 28); b) patient classification is inpatient (1); c) ICD10 primary diagnosis code is in range J40-J44
1.6	**Denominator**	Number of patients on practice disease register for COPD as of 31 March 2015
1.7	**Methodology**	Numerator divided by denominator Represented as emergency COPD admissions per 100 patients on COPD disease register
Section 2: Rationale		
2.1	**Purpose**	To highlight and compare the rate of hospital emergency admissions due to complications associated with COPD as a proxy for the effective management of the condition.
2.2	**Evidence and Policy Base**	COPD is one of the most common respiratory diseases in the UK. It usually only starts to affect people over the age of 35, although most people are not diagnosed until they are in their 50s. It is thought there are more than 3 million people living with the disease in the UK, of which only about 900,000 have been diagnosed. This is because many people who develop symptoms of COPD do not get medical help because they often dismiss their symptoms as a 'smoker's cough'. COPD affects more men than women, although rates in women are increasing. Good treatment of COPD can make a dramatic difference to quality of life and reduce emergency hospital admissions. Emergency admissions due to exacerbations of COPD can often be avoidable if treatment is carried out well and appropriately. Emergency admissions due to exacerbations of COPD can therefore be used to an extent as a proxy for the quality of management of the condition, including the optimal use of medicines.
Section 3: Data		
3.1	**Data source**	NHS England General Practice High Level Indicators https://www.primarycare.nhs.uk/
3.2	**Data owner & contact details**	NHS England General Practice High Level Indicators https://www.primarycare.nhs.uk/
3.3	**Time Frame**	Refreshed periodically with 12 months accumulated data Data available from April 2013
3.4	**Data quality assurance**	None provided

Hospital Trust Comparators

BIOSIMILARS: % of Infliximab biosimilars uptake

Section 1: Introduction / Overview		
1.1	**Title**	% of Infliximab biosimilars uptake
1.2	**MO Theme**	BIOSIMILARS
1.3	**Definition**	The percentage of defined daily doses for the biosimilar versions of infliximab
1.4	**Reporting Level**	Hospital Trust
1.5	**Numerator**	The number of defined daily doses for the biosimilar versions of infliximab
1.6	**Denominator**	The total number of defined daily doses for all infliximab (originator and biosimilar)
1.7	**Methodology**	The numerator divided by the denominator. Represented as the percentage of defined daily doses for the biosimilar versions of infliximab The percentage is calculated using the reported number of defined daily doses for biosimilar versions of infliximab (Inflectra and Remsima) NHSBSA do not receive actual figures for the numerator or denominator, just percentage figures at trust level, therefore this comparator cannot be calculated or presented for other geographies.
2.1	**Purpose**	Competition between different biological medicines, including biosimilar medicines, creates increased choice for patients and clinicians, and enhanced value propositions for individual medicines. This is particularly relevant in the context of Future Focused Finance which is looking at how the NHS can be supported to take value based decisions. There are additional benefits, such as further sources of supply. Biosimilar medicines are more challenging and expensive to develop than generic medicines, but there are significant savings associated with increased competition between biological medicines, including biosimilar medicines. Many Trusts have introduced active and successful programmes to implement the use of biosimilar infliximab in gastroenterology & rheumatology patients. This work has been collaborative with clinicians and patients and has resulted in significant savings for the health economies that allows funding to be used for other healthcare. https://www.england.nhs.uk/wp-content/uploads/2015/09/biosimilar-guide.pdf
2.2	**Evidence and Policy Base**	Biosimilars have been licensed by the appropriate regulator (MHRA or EMA) and is a biological medicine which is highly similar to another biological medicine already licensed for use which has been shown not to have any clinically meaningful differences from the originator biological medicine in terms of quality, safety and efficacy. Continuing development of biological medicines, including biosimilar medicines, creates increased choice for patients and clinicians, increased commercial competition and enhanced value propositions for individual medicines.
3.1	**Data source**	The data is extracted from the NHS Improvement Model Hospital Dashboard – Pharmacy and Medicines compartment. This data is sourced from the Rx-info Define system which is used by acute trusts
3.2	**Data owner & contact details**	Andrew Davies, Professional Lead for Hospital Pharmacy, NHS Improvement Andrew.davies@nhs.net
3.3	**Time Frame**	Refreshed quarterly with monthly data Data available on a 13 month rolling basis
3.4	**Data quality assurance**	The data used is the individual trusts own data. In line with the Carter methodology this data is reflected back to organisations through the model hospital and trusts are required to review and raise any issues through the NHSI.Productivity@nhs.net email address. Individual data points are not validated by NHS Improvement

PATIENT EXPERIENCE: CQC In-patient Survey (2015) Q60 to Q63

<table>
<tr><th colspan="3">Section 1: Introduction / Overview</th></tr>
<tr><td>1.1</td><td>Title</td><td>CQC In-patient Survey (2015) Q60 to Q63</td></tr>
<tr><td>1.2</td><td>MO Theme</td><td>PATIENT EXPERIENCE</td></tr>
<tr><td>1.3</td><td>Definition</td><td>The sum of the mean scores for the responses to questions 60 to 63 in the Care Quality Commission in-patient survey (2015), expressed as a percentage of the maximum possible score of 40.

Q60 “Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand”?

Q61 “Did a member of staff tell you about medication side effects to watch for when you went home?”

Q62 “Were you told how to take your medication in a way you could understand?”

Q63 “Were you given clear written or printed information about your medicines”</td></tr>
<tr><td>1.4</td><td>Reporting Level</td><td>Hospital Trust</td></tr>
<tr><td>1.5</td><td>Numerator</td><td>The aggregated mean score for the responses to questions 60 to 63</td></tr>
<tr><td>1.6</td><td>Denominator</td><td>40 (maximum possible score for Q60 to Q63)</td></tr>
<tr><td>1.7</td><td>Methodology</td><td>Numerator divided by denominator

Represented as the percentage of the maximum possible score of 40

Scoring system for Q60 to Q63

<table>
<tr><th>Response</th><th>Q60</th><th>Q61</th><th>Q62</th><th>Q63</th></tr>
<tr><td>Yes, completely</td><td>10</td><td>10</td><td>10</td><td>10</td></tr>
<tr><td>Yes, to some extent</td><td>5</td><td>5</td><td>5</td><td>5</td></tr>
<tr><td>No</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>I did not need an explanation</td><td>n/a</td><td>n/a</td><td></td><td></td></tr>
<tr><td>I had no medicines</td><td>n/a</td><td></td><td></td><td></td></tr>
<tr><td>I did not need to be told how to take my medication</td><td></td><td></td><td>n/a</td><td></td></tr>
<tr><td>I did not need this</td><td></td><td></td><td></td><td>n/a</td></tr>
<tr><td>Don’t know / Can’t remember</td><td></td><td></td><td></td><td>n/a</td></tr>
</table>

Mean score for each question is calculated by totalling the score provided by each patient surveyed and dividing by the number of patients surveyed excluding n/a responses.

Due to the way NHSBSA receive the data at trust level this comparator cannot be calculated or presented for other geographies.

See technical document for details of how the survey was undertaken and the methodologies applied to analysing and presenting the findings.
http://www.cqc.org.uk/sites/default/files/20160608_ip15_technical_document.pdf

Hospital benchmark reports are also available via the following link.
http://www.nhssurveys.org/surveys/950</td></tr>
<tr><th colspan="3">Section 2: Rationale</th></tr>
<tr><td>2.1</td><td>Purpose</td><td>A measure of the information provided to patients, on discharge from hospital, about the side-effects of their medicines.</td></tr>
<tr><td>2.2</td><td>Evidence and Policy Base</td><td>According to NICE’s Medicines optimisation guidelines (published in March 2015) relevant information about medicines should be shared with patients and their family members or carers, where appropriate, and between health and social care practitioners when a person moves from one care setting to another, to support high-quality care.

An evaluation was undertaken by Monmouth Partners to provide NHS England with a better understanding of the value of its Medicines Optimisation (MO) Dashboard to patients. A recommendation from the evaluation was ‘Patient experience data for medicines is being</td></tr>
</table>

		collated nationally and should be included in the current MO Dashboard for NHS stakeholders. '*Understanding the patient experience*' is the first principle of medicines optimisation and this should be echoed through future reiterations of the MO Dashboard' .
Section 3: Data		
3.1	**Data source**	CQC - Care Quality Commission Adult Inpatient Survey (September 2015 to January 2016)
3.2	**Data owner & contact details**	http://www.cqc.org.uk/content/adult-inpatient-survey-2015
3.3	**Time Frame**	Refreshed periodically with 5 months of data Data available from September 2015
3.4	**Data quality assurance**	See 2015 In-patient Survey: Quality and Methodology Report http://www.cqc.org.uk/sites/default/files/20160608_ip15_quality_and_methodology_report.pdf

PATIENT SAFETY: Medicines Reconciliation

<table>
<tr><th colspan="3">Section 1: Introduction / Overview</th></tr>
<tr><td>1.1</td><td>Title</td><td>Medicines Reconciliation</td></tr>
<tr><td>1.2</td><td>MO Theme</td><td>PATIENT SAFETY</td></tr>
<tr><td>1.3</td><td>Definition</td><td>Percentage of adult inpatients receiving medicines reconciliation within 24 hours of admission</td></tr>
<tr><td>1.4</td><td>Reporting Level</td><td>Hospital Trust (aggregated to Area, AHSN, STP, Trust cluster and England)</td></tr>
<tr><td>1.5</td><td>Numerator</td><td>Total number of patients who received medicines reconciliation for all medicines undertaken (started) within 24 hours of admission to this care setting</td></tr>
<tr><td>1.6</td><td>Denominator</td><td>Total number of patients’ records including those that have both received and not received medicines reconciliation</td></tr>
<tr><td>1.7</td><td>Methodology</td><td>Numerator divided by denominator

Represented as proportion of patients receiving medicines reconciliation (%)

Data is provided by both NMRD (National Medicines Reconciliation Database) and ST (Safety Thermometer). Where a trust submits to both tools it is agreed between the NHSBSA and the Data provider as to which data is included in the dashboard.

NMRD: The data in the dashboard represents information for all trusts that populated data.

ST: The data in the dashboard represents information populated by trusts designated as ‘Acute’</td></tr>
<tr><th colspan="3">Section 2: Rationale</th></tr>
<tr><td>2.1</td><td>Purpose</td><td>The aim of medicines reconciliation on hospital admission is to ensure that medicines prescribed on admission correspond to those that the patient was taking before admission. Details to be recorded include the name of the medicine(s), dosage, frequency, and route of administration. Establishing these details may involve discussion with the patient and/or carers and the use of records from primary care.

The NHS has launched the medication safety thermometer which uses medicines reconciliation and some other measures to help trusts improve their medication safety and to focus on the issues of medication error and harm caused from medication error. The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Data for the metric has been sourced from the Safety Thermometer and also the National Medicines Reconciliation Database (NMRD).</td></tr>
<tr><td>2.2</td><td>Evidence and Policy Base</td><td>In 2007, NICE developed a Technical patient safety solution for medicines reconciliation on admission of adults to hospital (PSG001). It recommended that all healthcare organisations that admit adult inpatients should put policies in place for medicines reconciliation on admission. This includes mental health units, and applies to elective and emergency admissions.</td></tr>
<tr><th colspan="3">Section 3: Data</th></tr>
<tr><td>3.1</td><td>Data source</td><td>National Medicine Reconciliation Database (part of Oxford AHSN)

Safety Thermometer</td></tr>
<tr><td>3.2</td><td>Data owner & contact details</td><td>https://nww.nmrd.nhs.uk/home.aspx

www.safetythermometer.nhs.uk/index.php?option=com_content&view=article&id=3&Itemid=107</td></tr>
<tr><td>3.3</td><td>Time Frame</td><td>Refreshed quarterly with 12 months of accumulated data
Data available from January 2014</td></tr>
<tr><td>3.4</td><td>Data quality assurance</td><td>NMRD: There are 2 identifiable component stages to the process of MR which can be determined by measurable outputs:
<table>
<tr><th>Component stage</th><th>Measurable Output</th></tr>
<tr><td>Initiation of medicines reconciliation (1st stage)</td><td>Accurate drug history recorded AND Any discrepancies between pre-admission and admission medication have been identified and clearly documented</td></tr>
<tr><td>Completion of medicines reconciliation (2nd stage)</td><td>Discrepancies resolved in an appropriate time scale AND Written record has been made to clearly communicate outcomes of resolutions including justification of discrepancies</td></tr>
</table>
</td></tr>
</table>

		The database currently requires measurement of the initiation (1st stage) of MR undertaken within 24 hours because this is the historic measure agreed. The data collection sample size needs to be large enough to provide meaningful results. Many organisations choose to collect data from the whole of their service, however a minimum sample size in the order of 75% of the organisation's average daily admission rates derived from HES is suggested, and this has been included in the database for individual organisations. ST: None provided

PATIENT SAFETY: NRLS % of harmful incidents

Section 1: Introduction / Overview		
1.1	**Title**	NRLS - % of harmful incidents
1.2	**MO Theme**	PATIENT SAFETY
1.3	**Definition**	Number of medication incidents reported as causing low, moderate or severe harm or death as a proportion of all medication errors as reported to NRLS
1.4	**Reporting Level**	Hospital Trust (aggregated to Area, AHSN, STP, Trust cluster and England)
1.5	**Numerator**	Number of reported incidents of harm involving medicines
1.6	**Denominator**	Total number of all reported incidents involving medicines
1.7	**Methodology**	The number of reported incidents of harm involving medicines (incidents reported as resulting in either ' Low harm', 'Moderate harm', 'Severe harm' or a 'Death') divided by the total number of reported incidents involving medicines. Represented as a percentage of all medication incidents reported to NRLS.
Section 2: Rationale		
2.1	**Purpose**	The NRLS was established in 2003. The system enables patient safety incident reports to be submitted to a national database. This data is then analysed to identify hazards, risks and opportunities to improve the safety of patient care. http://www.nrls.npsa.nhs.uk/report-a-patient-safety-incident/about-reporting-patient-safety-incidents/
2.2	**Evidence and Policy Base**	Organisations with an open and honest reporting culture, where staff believe reporting incidents is worthwhile because preventative action will be taken, are likely to report a higher proportion of 'no harm' incidents than an organisation with a less mature reporting and learning culture Since the NRLS was established, over four million incident reports have been submitted by healthcare staff.
Section 3: Data		
3.1	**Data source**	NHS National Patient Safety Agency, NRLS Reporting https://improvement.nhs.uk/resources/organisation-patient-safety-incident-reports-28-september-2016/
3.2	**Data owner & contact details**	Nrls.datarequests@nhs.net
3.3	**Time Frame**	Refreshed 6 monthly with 6 months of data Data available from April 2014
3.4	**Data quality assurance**	https://improvement.nhs.uk/uploads/documents/Data_Handling_Notes_Sep16_FINAL.pdf

PATIENT SAFETY: NRLS reported medication incidents

Section 1: Introduction / Overview		
1.1	**Title**	NRLS reported medication incidents
1.2	**MO Theme**	PATIENT SAFETY
1.3	**Definition**	Number of medication incidents reported to NRLS per "activity"
1.4	**Reporting Level**	Hospital Trust (aggregated to Area, AHSN, STP, Trust cluster and England)
1.5	**Numerator**	Number of medication incidents reported to NRLS
1.6	**Denominator**	FCE days of hospital care
1.7	**Methodology**	Numerator divided by denominator Represented as the total incidents per 100,000 FCE days of hospital care
Section 2: Rationale		
2.1	**Purpose**	Organisations who do not have an open and honest reporting culture, and where staff do not believe reporting incidents is worthwhile, are likely to report fewer medication incidents given their overall activity than an organisation with a more mature reporting and learning culture. Whilst low reporting levels are always a concern, high reporting can be symptomatic of either good reporting or high levels actual problems (including issues of medication supply) This comparator aims to provoke local discussions about how to drive up reporting and ensure a learning culture.
2.2	**Evidence and Policy Base**	The NRLS was established in 2003. The system enables patient safety incident reports to be submitted to a national database. This data is then analysed to identify hazards, risks and opportunities to improve the safety of patient care. Since the NRLS was established, over four million incident reports have been submitted by healthcare staff.
Section 3: Data		
3.1	**Data source**	NHS National Patient Safety Agency, NRLS Reporting Safe Medication Practice Team, Nursing Directorate, NHS England NHS Digital
3.2	**Data owner & contact details**	Numerator: Nrls.datarequests@nhs.net Denominator: Hospital Episode Statistics (HES), NHS Digital http://content.digital.nhs.uk/searchcatalogue?q=title%3A%22Provisional+Monthly+Hospital+Episode+Statistics%22&area=&size=10&sort=Relevance
3.3	**Time Frame**	Refreshed 6 monthly with 6 months of data Data available from April 2014
3.4	**Data quality assurance**	The following link provides a document outlining the quality assurance regarding the numerator data. https://improvement.nhs.uk/uploads/documents/Data_Handling_Notes_Sep16_FINAL.pdf Denominator data – none provided

PATIENT SAFETY: Summary Care Records Utilisation

Section 1: Introduction / Overview		
1.1	**Title**	Summary Care Records Utilisation
1.2	**MO Theme**	PATIENT SAFETY
1.3	**Definition**	Number of times the Summary Care Record (SCR) is viewed by NHS Hospital Trusts as a percentage of the number of in-patient non-elective admissions
1.4	**Reporting Level**	Hospital Trust (aggregated to Area, AHSN, STP, Trust cluster and England)
1.5	**Numerator**	The number of times the SCR has been viewed at Trust level
1.6	**Denominator**	Number of non-elective admissions
1.7	**Methodology**	Numerator divided by denominator Represented as the number of times the SCR is viewed as a percentage of in-patient non-elective admissions Providers with utilisation greater than 100% indicates that the SCR would have been viewed by more than one clinician during a patient pathway
Section 2: Rationale		
2.1	**Purpose**	Access to the SCR facilitates safe and effective medicines optimisation on admission to hospital. In-patient non-elective admissions is used as the denominator as SCR is used within emergency and urgent care settings.
2.2	**Evidence and Policy Base**	SCRs have many benefits for patients and healthcare staff in urgent and emergency care settings (such as out-of-hours GP services and Emergency Departments). SCRs provide access to health information that has previously been unavailable, enabling authorised healthcare staff to make informed clinical decisions. Benefits to patients • SCRs are accessible to authorised healthcare staff treating patients in an emergency in England. This will be particularly useful when a patient cannot give information (for example if they are unconscious) or when they are away from home and are unable to see their own GP. • Patient care can be supported by healthcare staff having faster access to their medical information and patients may not be required to repeat information to different NHS staff treating them. For example, in a hospital setting, healthcare staff will be able to access a patient's SCRs immediately enabling faster assessment. • SCRs can support better, safer prescribing of medication for patients by providing up to date information on a patient's allergies, previous adverse reactions and medications. • SCRs will enable vulnerable patient groups and those patients that are unable to communicate well with healthcare staff. For example, a non-English speaking patient that could struggle to communicate their condition would no longer be disadvantaged as their SCR would be available to the treating clinician. • Additional information, such as end of life care plans and relevant diagnoses, may be available to inform clinical care where it is appropriate. Benefits to NHS healthcare staff • Important patient information will be available to authorised healthcare staff treating patients in an emergency where they had previously not had access to it. This will be particularly useful to NHS staff treating patients in an emergency, when a patient needs treatment out of hours or away from their local area. • SCRs contain details of a patient's key health information including medications, allergies and adverse reactions. This enables clinicians to feel more confident to treat patients. • Medicines reconciliation (where a patient's prescribed medication is checked against current medications to ensure there is no conflict) will become more efficient in hospital pharmacies as pharmacists will be able to immediately refer to the SCR in order to reconcile the medications prescribed to the patient. Further information on the SCR is available on the NHS Digital website.
Section 3: Data		
3.1	**Data source**	NHS Digital
3.2	**Data owner & contact details**	http://digital.nhs.uk http://systems.digital.nhs.uk/scr
3.3	**Time Frame**	Refreshed quarterly with month end data Data available from February 2015
3.4	**Data quality assurance**	Summary Care Record have their own internal quality process to assure the data they receive from various sources that contributes to SCR availability at Trust level. Best endeavours are made to ensure this data is accurate but due to the complex nature there may be some errors at times.