Department of Health
An Roinn Sláinte
Männystrie O Poustie
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General Medical Services Contract

Clinical Care Domain Guidance

Northern Ireland Contract Assurance Framework 2025/26

Contents

Introduction

This document sets out requirements of the Clinical Care Domain within the Northern Ireland Contract Assurance Framework document. The Clinical Care Domain covers areas previously included in the Quality Outcomes Framework and selected Enhanced Services. Practices are required to continue to code appropriately to record that good clinical care is being maintained. Practices are not required to make annual returns at this stage. SPPG will work with the General Practice Information Platform (GPIP) to provide feedback to practices. SPPG will continue to monitor outcomes through the GP clinical systems, and work/ discuss with NIGPC as necessary and required.

It is expected that care for all conditions will be delivered as clinically appropriate in accordance with national guidance issued by bodies such as National Institute for Clinical Excellence and using regional or local care pathways where available.

Any aspect of NICAF may be subject to verification checks by the SPPG. Please note where percentage is mentioned within indicators, this is for monitoring purposes only and not for threshold payments.

Asthma (AST)

Indicator

- The contractor establishes and maintains a register of patients with asthma
- AST003. The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 24 months that includes an assessment of asthma control using the 3 RCP questions.
- AST006NI. Mean carbon emissions per salbutamol inhaler prescribed to patients between 01/04/25 and 31/03/2026 (KgCO2e)

Atrial Fibrillation (AF)

Indicator

- The contractor establishes and maintains a register of patients with atrial fibrillation
- AF006NI The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA2DS2- VASc score risk stratification scoring system in the preceding 3 years (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more).
- AF007 In those patients with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy.

Cancer (CAN)

Indicator

- The contractor establishes and maintains a register of all cancers patients as a register of patients with a diagnosis of cancer excluding non-melanotic skin cancers diagnosed on or after 1st April 2003
- CAN003. The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 9 months of the contractor receiving confirmation of the diagnosis

Secondary prevention of coronary heart disease (CHD)

Indicator

- The contractor establishes and maintains a register of patients with coronary heart disease
- CHD002. The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 24 months) is 150/90 mmHg or less.
- CHD003NI. The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 3 years) is 5 mmol/l or less.
- CHD005. The percentage of patients with coronary heart disease with a record in the preceding 24 months that aspirin, an alternative anti-platelet therapy, or an anti- coagulant is being taken.

Chronic Kidney Disease (CKD)

Indicator

- CKD005NI. The practice establishes and maintains a register of patients aged 18 or over with CKD with classification of categories G3a to G5 (previously stage 3 to 5)
- CKD006NI The percentage of patients aged 18 or over on CKD register in whom the last BP reading is 140/90mmhg or less in preceding 24 months
- CKD007NI The percentage of patients aged 18 or over on CKD register with hypertension and proteinuria (UACR >30) on ACEi or ARB.

Chronic obstructive pulmonary disease (COPD)

Indicator

- The contractor establishes and maintains a register of patients with COPD
- COPD003. The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 24 months.
- COPD005NI. The percentage of patients with COPD and Medical Research Council dyspnoea grade ≥3 at any time in the preceding 12 months, with a record of oxygen saturation value within the preceding 24 months.

Dementia (DEM)

Indicator

- The contractor establishes and maintains a register of patients diagnosed with dementia
- DEM002. The percentage of patients diagnosed with dementia whose care has been reviewed in review in the preceding 24 months.
- DEM003. The percentage of patients with a new diagnosis of dementia recorded in the preceding 1 April to 31 March with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded between 24 months before and 6 months after entering on to the register.

Diabetes mellitus (DM)

Indicator

- The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed
- DM006. The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs).
- DM008. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 24 months.

- DM009. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 24 months.
- DM012. The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 24 months.
- DM022NI The percentage of patients with diabetes aged 40 years and over, with no history of cardiovascular disease , who are currently treated with a statin (excluding patients with type 2 diabetes and a CVD risk score of <10% recorded in the preceding 3 years)
- DM023NI The percentage of patients with diabetes and a history of cardiovascular disease (excluding haemorrhagic stroke) who are currently treated with a statin
- DM024NI The percentage of patients with diabetes, on the register in whom the last blood pressure reading (measured in the preceding 24 months) is 150/90mmHg

Heart failure (HF)

Indicator

- The contractor establishes and maintains a register of patients diagnosed with heart failure
- HF002NI. The percentage of patients with a diagnosis of heart failure (diagnosed on or after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment between 3 months before and 24 months after entering on to the register.
- HF003. In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB.
- HF004. In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction who are currently treated with an ACE-I or ARB, the percentage of patients who are additionally currently treated with a beta- blocker licensed for heart failure.

Disease registers for heart failure

There are two disease registers used for the HF indicators for the purpose of calculating ADPF:

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

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

Hypertension (HYP)

Indicator

- The contractor establishes and maintains a register of patients diagnosed with hypertension
- HYP003NI-The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 24 months is 140/90 mmHg or less
- HYP007-The percentage of patients aged 80 years and over with hypertension in whom the last blood pressure reading (measured in the preceding 24 months is 150/90 mmHg or less

Mental health (MH)

Indicator

- The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy
- MH002 - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 24months, agreed between individuals, their family and/or carers as appropriate
- MH003 - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 24 months
- MH007 - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 24 months
- MH011NI - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of a lipid profile in the preceding 24 months
- MH012NI - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 24 months

Disease register for mental health

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

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

Where a patient is recorded as being ‘in remission’ they remain on the Mental Health register (in case their condition relapses at a later date) but they are excluded from the denominator for mental health indicator.

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

should be recorded as such in their patient record.

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

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

Non-diabetic hyperglycaemia (NDH)

Indicator

- The contractor establishes and maintains a register for patients with non-diabetic hyperglycaemia
- NDH001NI -The percentage of patients with non-diabetic hyperglycaemia who have had an HbA1c or fasting blood glucose performed in the preceding 24 months. NDH is defined as an HbA1c on 42-47mmol/mol or a fasting plasma glucose (FPG) of 5.5-6.9mmol/l.

Palliative care (PC)

Indicator

- PC001. The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age.
- PC002. The contractor has regular (at least 3 monthly) multi-disciplinary case review meetings where all patients on the palliative care register are discussed.

Disease register for palliative care

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

Stroke and transient ischaemic attack (STIA)

Indicator

- The contractor establishes and maintains a register of patients with stroke or TIA
- STIA004NI. The percentage of patients with stroke and is shown to be non-haemorrhagic or a history of TIA who have a record of total cholesterol in the preceding 3 years.
- STIA005NI. The percentage of patients with stroke shown to be non-haemorrhagic, or a history of TIA, whose last measured total cholesterol (measured in the preceding 3 years) is 5 mmol/l or less.
- STIA007. The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 15 months that an anti-platelet agent, or an anti-coagulant is being taken.
- STIA010NI-The percentage of patients aged 79 years or under with a history of stroke or TIA in whom the least blood pressure reading (measured in the preceding 24 months is 140/90 mmHg or less
- STIA011NI-The percentage of patients aged 80 years and over with a history of

stroke or TIA in whom the last blood pressure reading (measured in the preceding 24 months is 150/90 mmHg or less

Influenza Vaccination

Indicator

- VI01NI-Percentage of at risk patients age 18-64 years inclusive who have received a seasonal influenza vaccine
- VI02NI-Percentage of patients age 65 years or over who have received a Seasonal influenza vaccine

Cervical screening (CS)

Indicator

- CS003NI-The percentage of females age 25-49 who have had a cervical screening test in the last 3 years
- CS004NI- The percentage of females age 49-65 years who have had a cervical screening test in the last 5 years

Childhood Immunisations

- Practice to submit their Childhood Immunisations Scheme plan to SPPG.
- The Practice must meet its obligations under its Childhood Immunisations Scheme plan as outlined in the GMS Contract.

Extended Anti-Coagulation (Warfarin / NOAC) Monitoring

Practices are required to:

1. Develop and maintain a register of all patients treated by the anticoagulation monitoring service.
2. Have systems in place for call and recall.
3. Work collaboratively with other professional healthcare staff when appropriate.
4. Follow referral policies when necessary to refer patient promptly to other services or relevant support agencies
5. Provide education to newly diagnosed patients, if initiated in practice
6. Record individual management plans and ensure compliance with monitoring arrangements especially for those patients who have difficulty complying with monitoring requirements.
7. Review clinical procedures
8. Maintain adequate records.
9. Follow current professional guidance and undergo appropriate training.
10. Carry out appropriate annual review

NOAC Monitoring

Monitoring of NOACs is also required.

Whilst the majority of patients on NOACs will not require the same intense monitoring that is needed for Warfarin patients, there are specific requirements as regards initiation, monitoring (particularly in patients with reduced renal function etc) and in transfer of patients from Warfarin to NOAC.

Review: All practices should perform an annual review**.**

USEFUL LINKS

Practices must refer to "*Guidance on the Use of Warfarin in Primary Care*" January 2014 v 2.0 for full details of the service outline and required competencies.

- http://primarycare.hscni.net/pdf/HSCB_Safe_use_of_warfarin_in_primary_care_guideline_v_2.0_Jan_2014.pdf
- http://primarycare.hscni.net/pharmacy-and-medicines-management/resources/cardiovascular/anticoagulants/
- Overview | Atrial fibrillation: diagnosis and management | Guidance | NICE – June2021

Health Care for Adults with a Learning Disability

GP Practices are required to:

1. Work in partnership with Trusts to provide optimum service to patients with Learning disability.
2. Liaise with the Trust Health Facilitator to establish an accurate register of patients to whom the service is to be provided. The register of patients eligible for this service is held by the Trusts.
3. Demonstrate systematic recall system for patients on the register.
4. Provide an initial health assessment for patients on the register and provision of a patient held action plan, which will be reviewed on an annual basis. The health check will follow the format set out in the Health Assessment Form. This plan should also form part of the patients "Person Centred Plan". The action plans should be reviewed annually and the outcomes updated.
5. Integrate the health check as part of the patient's personal health record.
6. Involve carers and support workers: Where family or paid carers are involved they can play a vital role in the patient's health care. With the consent of the patient where possible, they should be fully informed of the patient's health care needs, and supported as necessary.
7. Liaise with relevant local support services. Liaison with community and learning disability health professionals, social services and educational support services is necessary to provide seamless care for patients and their carers.

Chronic Respiratory Conditions

Chronic Respiratory Conditions is made up of **two** parts:

1. Practice-based service for patients with COPD
2. Practice-based service for patients with Asthma

Practices are expected to provide both parts of the service.

USEFUL LINKS

- NICE Guidance- NG 115 last updated January 2019: Overview | Chronic obstructive pulmonary disease in over 16s: diagnosis and management | Guidance | NICE
- Primary Care Respiratory Society UK: http://www.pcrs-uk.org
- Global Initiative for Chronic Obstructive Lung Disease - Global Initiative for Chronic Obstructive Lung Disease - GOLD
- The documents below are available on the Primary Care Intranet.
    - NI COPD Integrated Care Pathway (May 2012)
    - NI COPD Self-Management Plan

Part 1 - Practice-based service for patients with COPD

Practices are required to:

1. A 24 month review (at least one review in a 24 month period) for patients on the COPD register, with an appropriately trained clinician. Whilst a face to face review is preferred this may be performed remotely if the patient is clinically stable.
2. Stratification of disease using current NICE recommendations. Assessment of the severity of the condition using the MRC Dyspnoea Scale. Education and management should be appropriate to the stage of the illness.
3. Medication review as per Regional COPD Medicine Management Guidelines.
4. Review inhaler selection and consider low carbon options. Promote patient education on the environmental impact of inhalers.
5. Review of the self-management plan including a record of the number of acute exacerbations in the previous year.
6. Measurement of oxygen saturation
7. Assessment of inhaler technique. May be performed remotely
8. Assessment of palliative care and end of life needs using prognostic Indicators.
9. Patient education including anticipatory prescribing using a validated self-management plan
10. Reduction of risk factors
    a. Recording of smoking status and referral for specialist smoking services
    b. Occupational risk factors and air pollution should also be considered and appropriate advice given
11. Referral to community services using regional or local pathways
12. Annual review and audit

Part 2 - Practice-based service for patients with Asthma

This part aims to enhances treatment and care to ensure that disease management is optimized and disease progression and adverse outcomes are minimized.

USEFUL LINKS

- The British Thoracic Society (BTS), National Institute for Health and Care Excellence (NICE) and Scottish Intercollegiate Guidelines Network (SIGN), have produced a joint Guideline for the Diagnosis, Monitoring and Management of Chronic Asthma. Asthma | British Thoracic Society | Better lung health for all
- Recommendations | Asthma: diagnosis, monitoring and chronic asthma management (BTS, NICE, SIGN) | Guidance | NICE
- Global Initiative for Asthma - Global Initiative for Asthma - GINA
- 3.0 Respiratory System | NI Formulary (hscni.net)

The following resources are available on the primary care intranet

- Asthma self-management plan
- PresQuipphttp://primarycare.hscni.net/download/DocLibrary/Pharmacy/Clinical/Respiratory/251-asthma-20.pdf
- http://primarycare.hscni.net/download/DocLibrary/Pharmacy/Clinical/Respiratory/PrescQIPP-295-Inhaler-Carbon-Footprint-22.pdf

Practices are required to perform :

1. A 24 month review (at least one review in a 24 month period) for patients on the **Asthma register** with an appropriately trained clinician. This may be performed remotely via telephone, zoom or similar if the patient is stable. However, it should be converted to a face to face consultation if clinically required or if the patient requests this. Code as you would have previously done for **Annual asthma review.**

2. Alternatively, a **telephone review (follow up respiratory assessment)** for patients on the **asthma register** on a **SABA only**, who would previously fulfil **exception reporting criteria** for the purposes of QOF and would otherwise not avail of an asthma review. Code as **follow up respiratory assessment**

Defined standards for asthma review should include the following:

Diagnosis and assessment of asthma control
Initial diagnosis should be with the appropriate use of spirometry as per NICE guidance and following current infection control guidelines

On the telephone assess asthma control using the Royal College of Physicians (RCP) Three Questions:

1. In the last month/week have you had difficulty sleeping due to your asthma (including cough symptoms)?
2. Have you had your usual asthma symptoms (e.g., cough, wheeze,chest tightness, shortness of breath) during the day?
3. Has your asthma interfered with your usual daily activities (e.g., school, work, housework)?

Note: one 'yes' indicates medium morbidity and two or three 'yes' answers indicate high morbidity.

If the patient answers yes to any of the 3 questions they should be advised of the increased risk and advised to attend for a face-to-face review. If they decline this should be documented in the clinical record.

Asthma Control Test

Welcome to the Asthma Control Test

Patients on high dose therapies and patients on continuous or frequent use of oral steroids should be considered for specialist referral.

Identification of other allergic conditions
A third of people with rhinitis will develop symptoms of asthma and over half of asthma suffers will also have rhinitis. Assessment and treatment of rhinitis should be part of routine asthma reviews

Discussion of current treatment and recommendations for change
This could encompass concordance with prescribed medication, concerns about side-effects, perceived efficacy of medication and compliance. Treatment may be adjusted in line with BTS-SIGN management guidelines.

If during telephone review the patient requires a change in their inhaler regime they should be advised to attend for a face-to-face review to demonstrate inhaler technique. If they decline this should be documented in the clinical record.

- The level of medication should be appropriate to the severity of the condition.
- Consideration should be given to inappropriate use of home nebulisers.
- Assessment of inhaler technique will form part of this review. The patient should be advised that assessment of inhaler technique is recommended at 24 month review and advised this is not available through telephone review. They should be offered a face-to-face review to provide this, if they decline this should be documented in the patient record.
- Steroid alert cards should be carried by all patients on high dose inhaled steroids.
- Choice of device should be considered on basis of ability to use the inhaler, patient acceptability, carbon footprint and cost. Check medication adherence and inhaler technique before each step up of treatment for asthma.

Self-management education
Issuing a personalised asthma action plan or reviewing an existing plan is an important component of an asthma review. ‘Be in Control’ asthma action plans are available from Asthma UK. Practices should provide each patient (over age 15 years) with self-management training and a patient held asthma action plan. Patients ideally should contribute to their own written plans over time. Examples of such plans are available e.g. from Asthma UK. For patients under 15 years of age the practice will provide the child or parent (as appropriate) with the action plan.

READ codes
For a Face to Face review as clinically appropriate (at least one asthma review in a 24 month period) (may be performed remotely as outlined above code as asthma annual review)

66YJ. Asthma annual review (EMIS/Vision)

For a telephone (follow up respiratory assessment) review for those patients on the asthma register on a **SABA only**, who would fulfil **exception reporting criteria** for the purposes of QOF and would otherwise not avail of an asthma review

6632. Follow-up respiratory assessment
212G. Asthma resolved

Additional Monitoring of Amber Drugs

Red Amber List

The Red Amber List of specialist medicines is a guide for practitioners in both Primary and Secondary care. It provides professional guidance on where prescribing responsibility should lie for these specialist medicines thus ensuring clinicians make an informed choice with regard to their prescribing thereby facilitating access to these medicines by patients throughout Northern Ireland. The Regional Group on Specialist Medicines, a subgroup of the Strategic Planning and Performance Group (SPPG) Medicines Management Forum is responsible for the maintenance of the list and any up-dates.

Amber List

The Amber List is an advisory list where it is considered by the Regional Group that responsibility for prescribing may be transferred from secondary to primary care when agreed shared care arrangements have been established. It is recommended that shared care arrangements should be drawn up following local discussion and agreement by prescribing parties.

A shared care guideline (SCG) details the respective clinical responsibilities of both parties.

AIMS

- Safe prescribing and monitoring of high-risk specialist medicines.
- Effective communication between secondary and primary care.
- Clarity about responsibility for monitoring after initial diagnosis or assessment in secondary care.
- Prescribing and monitoring that is convenient to the patient.

Practices are required to:

- Maintain a register of patients currently prescribed amber shared care drugs requiring additional monitoring. Individual patient records should record;- Indication, date started, last hospital appointment, status of shared care arrangement and copy of SCG.
- Identification of responsibility for ongoing monitoring where the GP is prescribing as indicated in the SCG. Drug monitoring status should be coded using the relevant read codes for “high risk drug monitoring”.
- Systematic call and recall of patients on the register who require monitoring. This would include follow up of non-attendees either in a hospital or general practice setting.
- Individual management plans which gives reasons for treatment, planned duration, monitoring timetable, and if appropriate, the therapeutic range to be obtained.
- Education and continuing information for patients. Education and advice will normally be provided by the specialist during initiation and stabilization. The provider should ensure that all patients prescribed amber drugs receive, or have received, appropriate education and advice on their condition and the medicines used to treat it. This should include written information where necessary.
- Communication with the specialist responsible for continuing care.
- To inform the specialist if unwilling to prescribe or enter into shared care arrangements on clinical grounds according to the SCG. This should be in writing giving reasons and a copy placed in the patients’ medical record.

- To communicate relevant tests results and any action taken to the responsible specialist.
- Provision of a prescription for an amber drug when shared care arrangements have been agreed.

The list of drugs eligible for Shared Care Agreements will be reviewed on a regular basis and new drugs may be added or existing drugs removed depending on the monitoring requirements of the SCG.

READ CODES

Practices must use the following Read codes in recording patient details and subsequent searches for data reporting and annual review.

	Status of responsibility	Read code
High risk drug monitoring Secondary Care	GP prescribing, specialist responsible for follow up including monitoring	66P9
High risk drug monitoring Shared care	GP prescribing, specialist responsible for clinical follow up and GP monitoring if appropriate.	66P8
High risk drug monitoring Primary care	GP prescribing, no specialist follow up and GP monitoring if appropriate.	66P7
High risk drug monitoring Review		8BS0.

ANNUAL REVIEW

Practices should undertake an annual review which should include a self-assessment of their systems, processes and register.

USEFUL RESOURCES

GMC -Good practice in proposing, prescribing, providing and managing medicines and devices prescribing-guidance-updated-english-20210405_pdf-85260533.pdf

The latest version of the full Red Amber List is available at

- http://www.ipnsm.hscni.net/red-amber/

A Shared Care Guideline (A-Z by Generic Name) for each drug is available at

- http://www.ipnsm.hscni.net/shared-care-guidelines/

Guidance on Primary -Secondary Care interface;

Working-Better-Together-Guidance-on-Primary-Secondary-Care-Interface-in-NI-Principles-Document-Re-issued-March-2025-Final.pdf

Drug	Specialty
Apomorphine	Neurology
Azathioprine	Post Solid Organ Transplant
Azathioprine	Dermatology/Gastroenterology/Haematology/ Immunology Neurology/ Ophthalmology/Respiratory/Rheumatology
Ciclosporin	Post Solid Organ Transplant
Ciclosporin (oral)	Dermatology/ Gastroenterology/ Haematology/ Immunology/ Neurology/ Ophthalmology/ Respiratory/ Rheumatology
Cinacalcet	Endocrinology/ Renal
Colistimethate (inhaled)	Respiratory only
Cyclophosphamide (oral)	Dermatology/ Immunology/Nephrology/ Neurology/ Respiratory/ Rheumatology

Denosumab	Rheumatology/Oncology
Dimethyl Fumarate	Dermatology
Dronedarone	Cardiology
Growth Hormone (Somatropin) Growth Hormone (Erythropoietin)	Endocrinology Refer to local guidelines in the West for Erythopietin and Darbepoetin
Growth Hormone (Darbepoetin)	
Hydroxycarbamide	Dermatology/Haematology
Leflunomide	Rheumatology
Lithium	Mental Health
Mercaptopurine	Gastroenterology only
Methotrexate (oral)	Dermatology/ Gastroenterology/ Neurology/ Ophthalmology/ Respiratory/ Rheumatology
Methotrexate (subcutaneous)	Dermatology/ Rheumatology
Mycophenolate mofetil	Post Solid Organ Transplant
Mycophenolate mofetil	Dermatology/ Gastroenterology/ Immunology/Haematology/ Neurology/ Ophthalmology/ Rheumatology

Penicillamine	Rheumatology
Riluzole	Neurology
Sirolimus	Post Solid Organ Transplant
Sodium aurothiomalate	Rheumatology
Somatropin (Growth Hormone)	Endocrinology
Sulfasalazine	Gastroenterology/ Rheumatology
Tacrolimus	Ophthalmology
Tacrolimus	Post Solid Organ Transplant
Tolcapone	Neurology

Structure Brief Advice for Alcohol

Alcohol misuse has many significant acute and long-term health effects and is a serious health issue. The total number of alcohol-specific deaths registered in 2022 was 356. This was six more than the previous year (350) and, accounted for 2.1% of all deaths registered in 2022.

There is extensive evidence to show that primary care-based interventions are very effective at reducing drinking at both hazardous and harmful levels.

NICE guidance 115 (February 2011) advises the use of a formal assessment tool, such as the AUDIT (**A**lcohol **U**se **D**isorders **I**dentification **T**est) tool, to assess the nature and severity of alcohol misuse and outlines interventions for alcohol misuse.

The ALCOHOL MOT, based on the AUDIT tool, has been designed by the Public Health Agency in NI to support those working in primary care to carry out alcohol brief interventions.

MOT Part 1 enables patients to work out if they are drinking at hazardous or harmful levels.

MOT Part 2 helps motivate and support patients to reduce their drinking. Both tools are designed so that a practitioner can work through them with a patient, or a patient can work through them alone.

Practices are required to

- To develop a practice protocol for alcohol screening using the AUDIT screening tool.
- To review existing practice protocol for alcohol screening using the AUDIT screening tool.
- To improve detection of high-risk alcohol consumption for patients aged over 18 years whose drinking may pose a risk to their health.
- To advise, manage and follow up patients as clinically appropriate depending on the screening result.

Opportunistic screening of patients aged over 18 years not seeking treatment for alcohol problems, in particular those with relevant conditions and who may be at increased risk of harm from alcohol, using the AUDIT screening tool and coding that screening has been performed.

Screening Step 1:

- The first step in screening involves answering the first 3 questions of the AUDIT tool only (Section A in the MOT 1 leaflet in appendix). This will provide an AUDIT-C Score.
- If the AUDIT-C score is 5 or more for a man, or 4 or more for a woman then a full AUDIT screen with all 10 questions should be performed.
- If only an AUDIT-C screen is completed code = 9k17

Screening Step 2:

- All 10 questions of the AUDIT tool (Section B in the MOT 1 leaflet in appendix) need to be completed if the AUDIT-C score is 5 or more for men, 4 or more for women.
- If only a full AUDIT screen is completed code = 9k15

NOTE: Only one code for screening (either AUDIT-C or Full AUDIT) should be used for each patient screened

Screening Step 3:

Following AUDIT screening patients should be given face to face feedback of any positive screening result (AUDIT score of 8 or more).

- GPs should manage and follow up patients as clinically appropriate according to the screening result and protocol developed in practice.
- **GPs should ensure that all positive AUDIT screening results are acted upon appropriately.**

Review of existing Practice Protocol for alcohol screening using the AUDIT screening tool.

Those practices which provided this service in previous years and have already developed a Practice Protocol for screening using the AUDIT screening tool should undertake a review of this Practice Protocol. This practice protocol review should be documented and retained at practice level. It should be undertaken with the involvement of relevant members of the practice team, including GPs and Nurses. The focus of this review should be on identifying areas for improvement of the system of screening in practice.

Resources for Practice Protocol development:

1. www.knowyourlimits.info
2. A Northern Ireland version of the AUDIT tool is available on the primary care intranet (MOT 1 and MOT 2) and can be accessed using the following link:-http://primarycare.hscni.net/general-medical-services-gms/enhanced-services/niles/structured-brief-advice-alcohol/
3. NICE guidance 115 Alcohol Use Disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence, February 2011 (reviewed July 2019) Overview | Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence | Guidance | NICEhttp://guidance.nice.org.uk/CG115
4. Drug and Alcohol Directories of Services http://www.publichealth.hscni.net/publications/drug-and-alcohol-directories-service

GP Long Term Condition Care and Key Information Summaries (Previously called Anticipatory Care planning)

Patients living with long term conditions represent a significant element of GP workload.
Patients with long term conditions and those with palliative care needs benefit from proactive management of their conditions.

Practices are required to:

1. **Development and maintenance of a register of patients with long term conditions who the practice determines as clinically appropriate to include:**

    - Patients on the Palliative care register
    - Chronic degenerative neurological condition such as Multiple Sclerosis, Parkinson's Disease, Motor Neurone Disease
    - Complex co-morbidity, ie the existence of two or more long term conditions such as
        a. Respiratory disease (asthma, COPD, bronchiectasis)
        b. Cardiovascular disease (heart disease, stroke, TIA)
        c. Diabetes
        d. Dementia
        e. Heart Failure
        f. End stage chronic kidney disease, and
        g. Any other patients as deemed appropriate by the practice.

    - Patients who have had two or more unscheduled hospital admissions in the last year
    - Patients identified using palliative and end of life care indicator tools (e.g. SPICT or GSF) including AnticiPal search or as part of Identification of End of Life enhanced service

Coding
All patients identified in the categories above should be coded as :
9OE6 (Chronic Long Term disease management required: complex needs)

2. **Where clinically appropriate, identify and record existing record of patient wishes or Advance Care Plan Summary or formal advance decision to refuse treatment**

3. **Medicines review**

    Practice pharmacists or GPs can complete the medicines review where clinically appropriate. Community pharmacy should be informed of any changes as appropriate.

4. **Structured Holistic review as clinical appropriate by an appropriate member of the practice team and completion of medical care plan template**

This should be completed as clinically appropriate for patients identified and reviewed as felt necessary

Patients who have had a stroke only need one care plan unless they require annual review due to being in one of the other categories, or have another stroke.

a. Check Medicines review has been completed and advance care plan has been offered
b. The medical care plan should be developed ideally after a review of the patient. Input should be sought from other professionals involved with the patient's care and relatives
c. **For some (but not all) patients** it may be appropriate to consider a Do Not Attempt CPR (DNACPR) decision. A copy of the DNACPR decision/medical care plan should be left with the patient/carers/nursing home
d. A copy of the medical care plan should be included in the patient records
e. The medical care plan should then be used to complete a Key Information Summary (KIS) and upload it to ECR subject to patient consent.
f. The Special notes box on the KIS should be used to record the existence **and location** of any advance care planning summary or advance directive to refuse treatment or DNACPR decision (e.g. in patients hand held records, with nursing home manager)

KIS is the preferred template for collection and sharing of information

Patients with capacity should be asked for their consent to upload KIS to ECR. KIS should be uploaded with consent or if not uploaded a note of dissent should be recorded. GPs may make a best interest decision to upload KIS for patients who do not have capacity to make that decision themselves.

NB For the purposes of this service patients in permanent and temporary nursing/residential beds should have Medical Care Plans completed through the new NILES Proactive GP Care for Nursing and Residential Homes and as a result these patients are **excluded** from this service.

Electronic record notes summary verified
EMIS/Vision Read Code **93440**

Dissent for KIS upload
Read code **9Nds**