

**Report for the Royal College of General Practitioners on the
development of a set of prescribing safety indicators
for use in revalidation**

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1. Purpose of document

The purpose of this document is to report on the first phase of a project undertaken to identify a set of prescribing safety indicators for the purposes of revalidation of general practitioners in the UK.

2. Background

Prescribing medications is one of the most powerful tools available to general practitioners in the prevention and treatment of disease and alleviation of symptoms. Not surprisingly however medication related adverse events are an important source of patient morbidity, much of which could be prevented by the highest quality prescribing and medicines management.^{1,2,3,4}

Given the importance of prescribing by general practitioners, it is appropriate that potential indicators of the quality and safety of prescribing are considered in any scheme for revalidation.

There have been many attempts over recent years to develop prescribing indicators in the UK and other countries. For example, numerous indicators have been developed based on the interrogation of prescriptions issued by general practitioners (e.g. using PACT data⁵). While potentially extremely useful for analysing prescribing patterns, these data are rarely linked to diagnoses and patient characteristics and so they have limitations when assessing quality and safety. Other indicators have required very detailed analysis and assessment of clinical records (e.g. the medication appropriateness index⁶), which would probably not be feasible for the large-scale assessment of all general practitioners in the UK. With developments in methods for interrogating electronic medical records, however, we now have the opportunity to develop and use sophisticated indicators that can give an assessment of the quality and safety of prescribing by individual general practitioners. It is this latter type of indicator that is the focus of current project.

3. Objectives of the report

- To outline the sources of information used in the project for identifying potential prescribing safety indicators
- To detail the process undertaken to develop the prescribing safety indicators
- To detail the process undertaken to achieve consensus on the appropriateness of using these indicators to assess the safety of prescribing of individual GPs
- To show the results from the consensus building exercise and to highlight those indicators considered appropriate for use in assessing the safety of prescribing of individual GPs for the purposes of revalidation
- To discuss the strengths, limitations and implications of the project
- To provide recommendations on the potential role of prescribing safety indicators for the purposes of revalidation of individual GPs

4. Methods

The project was overseen by a reference group (see Appendix 1) and consisted of the following elements:

- Deciding on the scope of the project in terms of what types of indicator to focus on
- Identification of potential prescribing indicators
- Developing evidence-based summaries for potential indicators
- Identification and selection of members of the consensus panel
- Use of the RAND appropriateness method to identifying potentially suitable indicators

4.1. Deciding on the scope of the indicators for the RCGP project

The original plan was to focus on the *appropriateness* of prescriptions issued by individual general practitioners and to have examples relating to high-quality prescribing associated with significant health gain and hazardous prescribing that might be associated with patient harm.

Having considered a large number of potential indicators the reference group came to the conclusion that it would be difficult to develop a set of indicators of high-quality prescribing for the purposes of revalidation. This is mainly because the potential indicators that we looked at describe optimal prescribing (often for long-term conditions) where prescribing decisions are likely to be made over time rather than at a single consultation. In these cases it is difficult to attribute the prescribing pattern to a single doctor, particularly in a group practice.

Therefore the reference group decided to focus on indicators of the safety of GP prescribing.

We agreed on the following **inclusion criterion**:

1. The indicator describes a pattern of prescribing that is potentially hazardous and may put patients at risk of harm

We also had the following **exclusion criteria**

1. The indicator describes a pattern of prescribing that could not easily be attributed to a single doctor
2. The indicator describes optimal prescribing for long-term conditions where prescribing decisions are likely to be made over time (potentially by more than one prescriber) rather than at a single consultation
3. The indicator describes a pattern of prescribing that is so unusual in UK general practice that the yield is likely to be too low to justify inclusion in the indicators set

4. It is unlikely to be feasible (without great effort) for the data required for the indicator to be extracted from general practice electronic health records

This approach allows us to focus on important safety issues for patients. While the prime purpose of developing the indicators is for revalidation, it would be possible for GPs to use the indicators to assess their own prescribing on a regular basis, for example for audit and for appraisals. If the use of the indicators were to lead reductions in hazardous prescribing, and improvements in medication monitoring, there could be significant health gains for patients.

4.2. Sources of information used for identifying potential prescribing indicators

Through knowledge of the world literature, and UK initiatives, on prescribing indicators, the following sources of information were used for the identification of potential prescribing indicators:

ACOVE^{7,8} (Assessing Care of Vulnerable Elders) – this RAND project (Wenger 2001) aimed to develop a set of evidence-based, quality of care indicators relevance to vulnerable older people using systematic literature reviews, expert opinion and guidance from expert groups and stakeholders. The indicators have been considered for use in the UK⁸ and the Netherlands. A multidisciplinary panel of 10 health professionals in the UK accepted 102 (86%) of the 119 quality indicators as being valid for use in England.⁸

Beers criteria⁹ - this is a set of criteria from the US for assessing potentially inappropriate medication use in people aged 65 years and older. The original list of criteria were published in the 1990s and updated in 2003.⁹

British National Formulary¹⁰ – this is a highly respected source of drug information for prescribers in the UK. The BNF was used in the current exercise for checking the validity of potential indicators.

Draft design specification for NHS IT systems aimed at minimising risk of harm from medications¹¹ - this report included a comprehensive literature review on risks of harm from medications in primary care² and provides examples of hazardous prescribing that could be used for the development of indicators.

Medication Appropriateness Index⁶ - this is a method for assessing the appropriateness of medication based on a range of factors such as indication, evidence for effectiveness, and directions and absence of important contraindications.⁶ Developed in the 1990s in the US its reliability has been assessed in different environments including primary care.⁶ While the principles behind the MIA are sound, it lends itself best to detailed analysis of prescribing based on clinical judgement, rather than interrogation of electronic medical records. It might be appropriate for use when analysing the prescribing of general practitioners where the use of indicators provide cause for concern.

National Patient Safety Agency (NPSA) documents - the NPSA¹² has produced a number of documents that are relevant to the safety of prescribing in primary care.¹³ For example, the fourth report from the Patient Safety Observatory¹⁴ highlighted medication incidents in the community and at the interface between community and hospital care and also suggested ways in which risks of harm could be reduced. In addition, the NPSA has highlighted a number of specific safety issues relevant to primary care including anticoagulant prescribing, dosing errors with opioid medicines and the prescribing of methotrexate.¹³ A number of these issues could be incorporated into indicators.

The National Service Framework for older people,¹⁵ and accompanying document “Medicines for older people - implementing medicines-related aspects of the NSF for older people”¹⁶ raise important issues regarding medicines used in older people. Specific indicators for assessing the quality and safety prescribing are not explicitly suggested, although many of the issues raised are covered in the approaches taken by ACOVE and Beers.

PINCER trial indicators - a cluster randomised trial took place in the UK between 2005-2009 to assess a pharmacist led intervention versus simple feedback in correcting clinically important problems in medicines management in general practices in England. The outcome measures for the trial represent important examples of hazardous prescribing, inadequate monitoring and potentially hazardous dosage instructions.¹⁷ Computer queries have already been written to extract data from the clinical computer systems in relation to these measures.

Preventable Drug Related Morbidity (PDRM) indicators - these are based on identifying preventable morbidity associated with drug use. The University of Manchester has adapted US indicators for use in the UK and along with the University of Nottingham has successfully used these indicators of electronic health records in general practices in England.¹⁸

Quality and Outcomes Framework¹⁹ – the QoF contains a number of prescribing related indicators. Most of these relate to the need to prescribe a particular drug for a particular clinical condition. There are also more general indicators of prescribing, including the need to undertake medication reviews.

STOPP and START tools²⁰ – these sets of indicators have been developed to assess the appropriateness of prescribing for older people (the STOPP tool relates to potentially inappropriate drugs and the START tool relates to potentially indicated appropriate drugs). The tools have been developed and validated by a team from Cork, Republic of Ireland.

4.3. Identification and selection of potential indicators

Potential indicators were identified through the above sources of information with Tony Avery initially selecting those indicators that:

- appeared to be within the scope of this exercise and
- appeared to fulfil criteria for being appropriate indicators²¹ in terms of:

- importance
- validity
- feasibility of data collection using electronic health records

The original reference sources and selected indicators were then reviewed by two members of the reference panel (Prof Helen Lester and Dr. Malcolm Campbell) who suggested including a small number of additional indicators from the original reference sources.

In addition, staff editors from the BNF checked through our first set of potential indicators and suggested additional ones based on their knowledge of the British National Formulary.

In total, 50 indicators were considered potentially suitable for consideration by the consensus panel. Of these, 44 came from a least one of the sources highlighted in Table 1 below; four came only from the British National Formulary and two came only from the “Draft design specification for NHS IT systems”.

Table 1: Numbers of potential prescribing indicators reviewed from different sources

| Source of indicators | Numbers of indicators reviewed | Numbers of indicators from each source considered potentially valuable for informing GP revalidation indicators* |
|--|--------------------------------|--|
| ACOVE | 217 | 2 |
| Beers criteria 2002 | 89 | 20 |
| PINCER trial | 11 | 6 |
| PDRM indicators | 29 | 4 |
| QoF clinical indicators relating to prescribing | 8 | 0 |
| QoF organisational indicators relating to medicines management | 10 | 0 |
| STOPP tool | 65 | 27 |

*it should be noted that there was some overlap in indicators between the different sources

4.4. Defining the indicators

For the purposes of the consensus group exercise we defined the indicators based on the wording used in previously published studies and reports. In places however we altered the wording to make the indicators more relevant to UK general practice, or we have been more specific about the drugs and conditions covered by the indicators.

For 13 of the indicators we produced one or more variations in the text to provide consensus panel members with different options for consideration. For example, while the prescription of beta blockers is contraindicated in asthma there is evidence to suggest that in various types of heart disease,

such as heart failure, the benefits may outweigh the risks. Therefore a variation on an asthma/beta-blocker indicator would be to exclude patients with cardiac conditions where benefits of beta-blockers may outweigh the risks.

For the purposes of the consensus group exercise we did not define the indicators in such a way that they could be immediately converted into unambiguous queries for running on GP computer systems. Nor did we phrase the indicators to take account of a doctor's volume of prescribing (whereby instances of hazardous prescribing might be considered as a proportion of overall numbers of prescriptions). These issues will be addressed in phase 2 of the project.

4.5. Developing the evidence-based summaries for the indicators

For each of the potential indicators the supporting evidence base was provided for consensus panel members. In theory we could have spent 6-12 months searching the literature for *each* potential indicator, but this was clearly not feasible. Instead we undertook rapid electronic searches of the literature and drew upon respected reference sources such as the British National Formulary, Martindale and Stockley's Interactions. We also showed the indicators to the team responsible for developing the content of the British National Formulary and they have provided background evidence for us.

The searches of reference sources (such as the British National Formulary, Martindale and Stockley's Interactions) were done by Dr Rachel Spencer, a junior doctor (GP registrar) in Nottingham. The rapid literature reviews were done by Brian Serumaga (pharmacist and PhD student with systematic review experience) and Dr Grant Dex (GP and DPhil student with expertise in evidence-based healthcare). Each rapid review took around 2-3 hours. Tony Avery read through all the draft evidence-based summaries and edited these based on his knowledge of the literature to produce the final version.

4.6. Identifying members for the consensus panel

In line with RAND methodology we aimed to identify a maximum of 12 panel members. We purposely selected two GPs with known expertise in therapeutics and one with experience of working with the BMA General Practices Committee.

In order to select the remaining members of the panel, we wrote to all RCGP faculties in the UK in March 2009 asking for volunteers and received back 58 replies. We took account of the following factors when selecting these additional members for the consensus panel:

- **Professional background:** all members of the panel were practising GPs

- **Employment status:** we selected a range different types of GP including partners, salaried GPs, a retainer scheme GP and a locum GP
- **Gender:** we had an equal mix of male and female GPs
- **Geography:** we had GPs from each of the countries of the United Kingdom
- **Professional roles:** we selected some GPs with experience of working as appraisers/assessors of GPs; we had one GP who is a BMA General Practice Committee member
- **Expertise:** all members of the panel had experience of prescribing in general practice; several members of the group had additional experience in therapeutics with at least one having a formal postgraduate qualification in therapeutics

We appointed 12 panel members with nine of these coming from a request for volunteers sent out to RCGP faculties. All panel members completed all aspects of the RAND consensus exercise.

4.7. Use of the RAND appropriateness method at to identifying potentially suitable indicators

Under the expert guidance of Dr Stephen Campbell, we used the RAND appropriateness method²²⁻²⁴ to identify potentially suitable prescribing safety indicators.

This consisted of a two-round exercise whereby panel members were asked to consider the evidence and rate, on a 9 point scale, the appropriateness of the different potential indicators for the assessment of:

- 1) The safety of prescribing of individual GPs
- 2) the safety of prescribing of individual GPs for the purposes of revalidation

The instructions given to panel members for scoring the indicators are shown in Appendix 2.

In brief, we explained the rating scale as follows:

“The rating scale is numbered 1-9 where:

- a score of 1 means you think it would be extremely *inappropriate* to use the indicator
- a score of 9 means you think it would be extremely *appropriate* to use the indicator
- across the spectrum:
 - scores of 1-3 mean that you think it would be *inappropriate* to use the indicator

- scores of 4-6 mean that you are *equivocal* about whether or not it would be appropriate to use the indicator
- scores of 7-9 mean that you think it would be *appropriate* to use the indicator

The number of panel members scoring 7 and above will be critical in deciding whether or not an indicator should be considered appropriate and be taken through to the field testing phase of the project.”

1st round assessment of the prescribing indicators

To give consensus panel members sufficient time to read the evidence-based materials, and to come to a decision on the rating of these, a period of just over 3 weeks was given. Consensus panel members were expected to spend at least a day on undertaking their first round assessments.

Panel members were instructed to send back their assessments the project team in Nottingham at least a week prior to the consensus panel meeting so that the results could be processed.

Data were entered onto a Microsoft Excel spreadsheet. In order to produce output in-line with RAND appropriateness methods, the following was prepared for each panel member:

- Numbers of panel members giving a particular appropriateness score (1-9) for each of the potential indicators in relation to both:
 - 1) The safety of prescribing of individual GPs
 - 2) the safety of prescribing of individual GPs for the purposes of revalidation
- Median value of the scores from all panel members for each of the potential indicators in relation to both:
 - 1) The safety of prescribing of individual GPs
 - 2) the safety of prescribing of individual GPs for the purposes of revalidation
- The panel members own score from the first round of the exercise for each of the potential indicators in relation to both:
 - 1) The safety of prescribing of individual GPs
 - 2) the safety of prescribing of individual GPs for the purposes of revalidation

While panel members were made aware of their own schools from the first round, the scores from other panel members were anonymised.

In preparation for the consensus panel meeting, the co-chairs of the meeting (Tony Avery and Stephen Campbell) were provided with the appropriateness scores of each of the panel members (along with median score) for each of the potential indicators in relation to both:

- 1) The safety of prescribing of individual GPs

- 2) the safety of prescribing of individual GPs for the purposes of revalidation

Consensus panel meeting

The consensus panel meeting took place on the evening of Monday 20th July and all day Tuesday, 21 July 2009. The meeting was held at the Royal College of General Practitioners in London.

On the evening of 20th July, Tony Avery gave panel members a brief resume of the project and Stephen Campbell gave a detailed account of the use of the RAND appropriateness method. He then took panel members through consensus building discussions around one of the potential indicators in order to help establish ground rules and methods of working. This exercise was followed by a meal specifically for the purpose of building up relationships and trust between panel members.

On 21st July the panel group members discussed the remaining potential indicators in turn. For each of these the panel was asked:

- What safety problem was represented by the indicator?
- Whether it was appropriate to use this indicator to assess
 - 1) The safety of prescribing of individual GPs
 - 2) The safety of prescribing of individual GPs for the purposes of revalidation

With knowledge of scores from the first round, Stephen Campbell encouraged panel members with diverging views to discuss these with a group (this was done without directing questions specifically at individuals known to have these diverging views).

Also, panellists were asked to consider whether they wished to:

- Propose an alternative wording for each indicator
- Propose any additional indicators

After discussion of each indicator, panel members scored the appropriateness of that indicator on a 1-9 scale in a similar way to the first round of the exercise, taking into account their previous scores, scores from other panel group members and the discussions that had taken place.

In addition, changes in wording were suggested for 21 of the indicators and two completely new indicators were proposed by panel group members. Each of these revised and new indicators was scored on the 1-9 scale by each of the panel members.

4.8. Production of final set of indicators

Following the consensus panel meeting, the scores of each panel member were entered on to a Microsoft Excel spreadsheet by a researcher. All data entered onto the spreadsheet were checked for accuracy against the original score sheets by an administrator.

For each indicator a median score was calculated and the distribution of scores was examined in relation to assessing:

- 1) The safety of prescribing of individual GPs
- 2) the safety of prescribing of individual GPs for the purposes of revalidation

A decision on whether there was **agreement** amongst panel members about whether indicator was appropriate for use was made using standard RAND appropriateness methods. We decided that there was agreement if:

- 1) The median score was seven or greater
- 2) No more than three panel members, voted outside the 3 point distribution around the median, e.g. if the median score was 7, no more than three panel members gave a score lower than 6 or greater than 8.

5. Results

Table 2 below shows 39 prescribing safety indicators where there was agreement from the consensus panel about their appropriateness for use in assessing the safety of prescribing of individual GPs for the purposes of revalidation.

The indicators have been split into the following categories:

- A: Cardiovascular and respiratory disease
- B: Central nervous system (including analgesics)
- C: Anti-infective agents
- D: Women's health and urinary disorders
- E: Musculoskeletal
- F: Hazardous care prescriptions, interactions and allergy
- G: Laboratory test monitoring

The labelling in the first column of the table is consistent with the labels used in the second round of the consensus exercise and the detailed results for all potential indicators considered are shown in Appendix 3. Indicators with an "X" in the first column are variations (or new) indicators suggested by the panel. In table 2, an additional 11 indicators are mentioned in the comments column that were considered appropriate by the panel, but are not detailed in the table because they are similar to those already in the table (these indicators were either given slightly lower levels of support from consensus panel members or were less comprehensive than those shown in table 2).

Table 2: Prescribing Safety Indicators where there was agreement from the consensus panel about their appropriateness for use in assessing the safety of prescribing of individual GPs for the purposes of revalidation

| Safety Indicator | | Median score | Comments |
|------------------|---|--------------|--|
| A | Cardiovascular and respiratory disease | | |
| A1(c) | Prescription of a beta-blocker to a patient with asthma (<i>excluding patients who also have a cardiac condition, where the benefits of beta-blockers may outweigh the risks</i>) | 8 | Taking account of cardiac conditions where the benefits of beta-blockers may outweigh the risks in asthma resulted in agreement for this indicator. |
| A3X | Prescription of short acting nifedipine (excluding patients with Raynaud's disease) | 7 | |
| A4(b) | In a patient with renal impairment, prescription of digoxin at a dose greater than 125 micrograms daily (e.g. CKD 3+) | 7 | |
| A5 | Prescription of digoxin at a dose of greater than 125 micrograms daily for a patient with heart failure who is in sinus rhythm | 8 | |
| A6 | Prescription of diltiazem or verapamil in a patient with heart failure | 7 | |
| A7 | In an older patient (>65yrs) the prescription of aspirin at a dose >75mg daily | 7 | |
| A7X | In an older patient (>65yrs) the prescription of aspirin at a dose >75mg daily for ≥ one month | 8 | This variation on A7 received slightly higher levels of support because it takes account of longer-term usage of aspirin. |
| A11 | The prescription of a long-acting beta-2 agonist inhaler to a patient with asthma who is not also using an inhaled corticosteroid | 8 | |
| B | Central nervous system (including analgesics) | | |
| B1(a) | The prescription of aspirin to a child aged 16yrs and under | 9 | |
| B1(b) | The prescription of aspirin to a child aged 16yrs and under, <i>where the child does not have Kawasaki's disease</i> | 9 | Although very rare, the exclusion of Kawasaki disease from this indicator means there are no indications for prescribing aspirin |
| B3(a) | In a patient with Parkinson's disease, the prescription of metoclopramide | 8 | |
| B3(b) | In a patient with Parkinson's disease, the prescription of prochlorperazine | 8 | |
| B4(b)X | In an older person (>65yrs), who is not receiving benzodiazepines or Z drugs on a long-term basis, the prescription of a benzodiazepine or Z drug for more than 21 days | 8 | B4(b) received similar levels of support but did not include Z-drugs. The inclusion of Z-drugs makes this indicator more comprehensive and avoids potential risk of switching to Z-drugs if these did not appear in the indicator. |

| Safety Indicator | | Median score | Comments |
|------------------|---|--------------|--|
| B5(b)X | In an older person (>65yrs) with depression initiation of benzodiazepine or Z drugs on a long-term basis (i.e. greater than 21 days) | 8 | B5(b) received similar levels of support but did not include Z-drugs (see comment above). |
| C | Anti-infective agents | | |
| C2(b) | Prescription of mefloquine to a patient with a history of convulsions | 8 | Indicator suggested by BNF team. |
| D | Women's health and urinary disorders | | |
| D1 | Prescription of a combined hormonal contraceptive to a women with a history of venous or arterial thromboembolism | 9 | |
| D2(a) | Prescription of oral or transdermal oestrogens to a woman with a history of breast cancer | 9 | |
| D3 | Prescription of oral or transdermal oestrogen without progesterone in a woman with an intact uterus | 9 | |
| D5X | Prescription of a combined hormonal contraceptive to a woman aged 35 years or older who is a current smoker. | 8.5 | Indicator suggested by the consensus group. |
| D6X | Prescription of a combined hormonal contraceptive to a woman with a body mass index of ≥ 40 | 8 | Indicator suggested by the consensus group. |
| E | Musculoskeletal | | |
| E1(a)X | Prescription of an NSAID to a patient with a history of peptic ulceration | 9 | A similar indicator (E1(a)) focusing non-selective NSAIDs was also supported. |
| E1(b)X | Prescription of an NSAID to an <i>older</i> patient (>65yrs) with a history of peptic ulceration | 9 | A similar indicator (E1(b)) focusing non-selective NSAIDs was also supported. |
| E1(c)X | Prescription of an NSAID, <i>without co-prescription of an ulcer healing drug</i> , to a patient with a history of peptic ulceration | 9 | A similar indicator (E1(c)) focusing non-selective NSAIDs was also supported. |
| E5X | In an patient with heart failure, the prescription of an NSAID | 8 | A similar indicator (E5) focusing on patients aged 65 years and older was also supported. |
| E6X | In a patient with chronic renal failure, the prescription of an NSAID (e.g CKD 3 or worse) | 8.5 | A similar indicator (E6) focusing on patients aged 65 years and older was also supported. |
| F | Hazardous co-prescriptions, interactions and allergy | | |
| F2 | Prescription of warfarin in combination with an oral NSAID | 7.5 | |
| F3 | Prescription of a phosphodiesterase type-5 inhibitor, e.g. sildenafil, to a patient who is also receiving a nitrate or nicorandil | 8 | |
| F4(b) | Prescription of clarithromycin or erythromycin to a patient who is also receiving simvastatin, <i>with no evidence that the patient has been advised to stop the simvastatin whilst taking the antibiotic</i> | 7 | Would be very difficult to extract reliable data for this indicator from a query of computerised GP records. |

| Safety Indicator | | Median score | Comments |
|------------------|--|--------------|---|
| F5(b) | Prescription of a potassium salt or potassium sparing diuretic (excluding aldosterone antagonists such as spironolactone) to a patient who is also receiving an ACE inhibitor or AR-II receptor antagonist | 8 | |
| F6 | Prescription of verapamil to a patient who is also receiving a beta-blocker drug | 8 | |
| F9 | Prescription of a penicillin containing preparation to a patient with a history of allergy to penicillin | 8.5 | When rating this indicator, panel members were asked to assume that the history of allergy to penicillin was correct. |
| G | Laboratory test monitoring | | |
| G1 | Prescription of warfarin to a patient without a record of INR having been measured within the previous 12 weeks | 8 | |
| G1X | Prescription of warfarin to a patient without a record of INR having been measured within the previous 12 weeks (excluding patients who self monitor) | 8 | This variation on G1 excludes patients whose INR results may not appear in the computer records because they self monitor. |
| G2X | Prescription of amiodarone without a record of liver function being measured in the previous 9 months | 8 | There was also support for G2 whether monitoring period was six months (as suggested in the BNF). |
| G3X | Prescription of amiodarone without a record of thyroid function being measured within the previous 9 months | 8 | There was also support for G3 whether monitoring period was six months (as suggested in the BNF). |
| G4X | Prescription of an ACE inhibitor or ARB without a record of renal function and electrolytes being measured prior to starting therapy | 8 | If ACE inhibitor or ARB initiated in hospital, the GP records may not contain evidence of renal function and electrolytes being measured prior to starting therapy. Indicator G4 also supported (where ARBs not included) |
| G5(b) | Prescription of lithium without a record of a lithium level being measured within the previous six months | 8 | BNF suggests at least three monthly monitoring (indicator G5), but this did not gain full support from the consensus group (median 6.5) |
| G6 | Prescription of methotrexate without a record of a full blood count within the previous three months | 8 | |
| G7 | Prescription of methotrexate without a record of liver function having been measured within the previous three months | 8 | |

6. Discussion

Thirty nine prescribing safety indicators (and 11 variations on these indicators) were identified by the consensus panel that were considered appropriate for use in assessing the safety of prescribing of individual GPs for the purposes of revalidation. These indicators cover a range of therapeutic areas and examples of hazardous prescribing and/or inadequate laboratory test monitoring.

6.1. Strengths and limitations of the project

The strengths of the project include:

- The wide range of sources used to identify prescribing safety indicators
- The use of a reference group to oversee the project and validate aspects of the work
- The involvement of staff editors from the British National Formulary in checking through our list of potential indicators, suggesting additional ones and helping provide some of the evidence for these
- The provision of evidence-based summaries for each of the indicators identified
- The identification of 12 GPs for the consensus panel with a wide range of characteristics
- The use of RAND appropriateness methods
- Involvement of Dr Steven Campbell who has particular expertise in the use of RAND appropriateness methods
- Careful recording and checking of data from the consensus panel

Nevertheless, there are a number of potential limitations and these are outlined below.

It is possible that we have not identified all sources of potential prescribing safety indicators and that additional sources might have provided further indicators that would then have been prioritised by the consensus panel.

While over 400 potential prescribing indicators were reviewed, the vast majority were not thought appropriate for use in the assessment of the safety of prescribing of individual GPs for the purposes of revalidation. Nevertheless, even though the sources of the indicators were checked by the lead author and two members of the reference group, it is possible that we did not include potential indicators that the consensus group might have considered appropriate.

The main reasons why the different types of indicators did not yield many candidates for GP revalidation are as follows:

ACOVE - many of these indicators relate to process measures, and to the care of patients with long-term conditions, rather than to prescribing decisions that could easily be attributed to one general practitioner.

Beers criteria 2002 – these provided the greatest number of potential indicators, but some of the Beers criteria relate to drugs not commonly used in the UK or issues that we felt were not of high clinical importance.

PDRM indicators - these indicators focus on a preventable morbidity associated with drug use, but from this information it would be difficult using electronic searches to identify which doctor(s) were responsible for the prescribing (or monitoring failures) that led to the preventable morbidity.

QoF clinical indicators relating to prescribing – as noted earlier, most of these relate to the need to prescribe a particular drug for a particular clinical condition, and this is considered outside the scope of the current exercise.

QoF organisational indicators relating to this is management - The more general indicators of prescribing, such as the need to undertake medication reviews, cannot easily be applied to the prescribing of an individual general practitioner in a group practice. Others, such as the possession and in-date emergency drugs to treat anaphylaxis, cannot be assessed through interrogation of the electronic health record.

STOPP indicators – We consider that many of these indicators highly relevant to general practice and variations on 27 of them were put to the consensus panel. Reasons for not including STOPP indicators included some that we did not consider to be of high enough clinical importance for the purposes of revalidation, and those where we felt it would be very difficult to extract relevant data from GP computer systems.

While we put considerable effort into providing evidence-based summaries for each of the indicators that panel members were asked to assess, it is possible that more extensive literature reviews would have identified further evidence that might have influenced the views of consensus panel members.

Also, while we also put considerable effort and expertise into running the consensus exercise using RAND appropriateness methods, it is possible that a different set of GPs would have made different judgements on the indicators.

Nevertheless, despite these potential limitations the project has been conducted in a rigorous manner and the GPs on the consensus panel were from a wide variety of backgrounds. It is likely therefore that the indicators we have identified would have face validity with most GPs practising in the UK.

7. Recommendations

The first phase of the RCGP prescribing safety indicators project has been conducted successfully with the identification of 39 indicators (and 11 variations on these indicators) that the consensus panel considered appropriate for use in assessing the safety of GP prescribing for the purposes of revalidation.

It is important now to go onto the second phase of the project which aims to:

- 1) Determine whether each indicator can be converted into a computer query capable of reliably assessing the safety of prescribing of individual GPs
- 2) To test the use of these queries on GP computer systems

When designing the project initially did not know how many potential prescribing safety indicators would be identified and prioritised by the consensus group. Within the further funding available from the Academy of Medical Royal Colleges (AMRC) it is unlikely that we will be able to address the above two aims with respect to all 39 of the indicators that have been identified. Nevertheless, through work done by PRIMIS+ and the PINCER trial team we have already developed and tested suitable computer queries for at least 15 indicators that are identical (or very similar) to those identified by the consensus process. In our plans for phase 2 of the RCGP prescribing safety indicators project we have agreed with the AMRC undertake further work on at least 10 additional indicators.

We therefore make the following recommendations:

- 1) For all 39 indicators (and 11 variations on these indicators) to work with colleagues on the reference group to exclude those where it is unlikely that a computer query can be developed capable of reliably extracting data from GP computer systems
- 2) To work with colleagues on the reference group to decide on at least 10 indicators to focus on for the development and testing of computer queries
- 3) To develop computer queries for at least 10 indicators

In addition, it is suggested that phase 1 of the RCGP prescribing safety indicators project is written up for publication.

Finally, it will not be possible to develop computer queries capable of assessing the safety of prescribing of *individual* GPs unless steps are taken to make it possible to reliably identify the electronic prescribing of individual GPs. Therefore it is recommended that the RCGP (continues to) stress the importance of this issue in discussions with the Department of Health and BMA General practices Committee.

8. Funding

This project was part-funded by the Academy of Medical Royal Colleges, to whom we are extremely grateful.

9. Acknowledgements

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11. Appendix 1: Reference Group

The project has been overseen by a reference group which includes (in alphabetical order):

- Dr Malcolm Campbell (GP)
- Dr Stephen Campbell (senior research fellow)
- Prof Helen Lester (academic GP and co-lead of the panel that reviews evidence for Quality and Outcomes Framework)
- Prof Mike Pringle (RCGP lead for revalidation and academic GP)
- Prof Ian Purves (head of the Sowerby Centre for Health Informatics)
- Prof Martin Roland (academic GP)
- Dr Martin Shelley (GP)

Members of the reference group have:

- Commented on and agreed:
 - the definition of the task
 - the proposed methods for the development and validation of the indicators
- Helped to identify and comment on the suitability of potential indicators
- Commented on/agreed the process for selection of consensus panel members
- Checked through materials to be sent out to consensus panel members
- Checked through/commented on the final report

12. Appendix 2: Instructions given to panel members on scoring the indicators

RCGP prescribing safety indicators project - instructions for panel members on scoring the indicators

Before reading this document, please read the “background information for consensus panel members” which provides important details of the rationale for developing the prescribing indicators, and the process undertaken to develop the indicators and accompanying evidence-based summaries. Your task is to give a score to each of the indicators. For each of the indicators you have been provided with an evidence-based summary and it is recommended that you read this before giving a score. For each of the indicators you will be asked to provide a score in relation to the following questions:

- 1) How appropriate would it be to use this as an indicator of the safety of prescribing by individual GPs?
- 2) How appropriate would it be to use this as an indicator of the safety of prescribing by individual GPs *for the purposes of revalidation?*

The reason we have asked these questions separately is because you may feel that an indicator is appropriate to assess the safety of GP prescribing, but that it would not be appropriate to use it *for the purposes of revalidation*. In such cases, an indicator might be appropriate to use in other circumstances such as error trapping or for the purposes of audit.

The rating scale is numbered 1-9 where:

- a score of 1 means you think it would be extremely *inappropriate* to use the indicator
- a score of 9 means you think it would be extremely *appropriate* to use the indicator
- across the spectrum:
 - scores of 1-3 mean that you think it would be *inappropriate* to use the indicator
 - scores of 4-6 mean that you are *equivocal* about whether or not it would be appropriate to use the indicator
 - scores of 7-9 mean that you think it would be *appropriate* to use the indicator

The number of panel members scoring 7 and above will be critical in deciding whether or not an indicator should be considered appropriate and be taken through to the field testing phase of the project.

Almost all of the indicators provided describe patterns of prescribing (or medication monitoring) that may be considered potentially hazardous and may

put patients at risk of harm. Therefore it could be argued that the indicators (as they are worded currently) do not measure the *safety* of GP prescribing but the opposite. It is likely, however, that if the indicators were used for the purposes of revalidation they would be reworded to take account of the volume of a GPs prescribing so that very low levels of hazardous prescriptions would be considered an indicator of safety.

For the purposes of this exercise please consider the indicators to represent *safety* in that a low level of potentially hazardous prescribing means relatively safe prescribing.

For example, one of the potential indicators concerns “prescription of a penicillin containing preparation to a patient with a history of allergy to penicillin”. When asked how appropriate it would be to use this as an indicator of the safety of GP prescribing you might rate this either 7, 8 or 9. This does not mean that you think that prescribing penicillin in these circumstances is a safe pattern of prescribing. In contrast, it means that you think this would be an ***appropriate indicator of the safety of prescribing of individual GPs*** in that a clinically active doctor with no examples of such prescribing is likely to be safer than one with several examples of prescribing penicillin to patients with penicillin allergy. Also, if used as an indicator for revalidation, it is likely that account would be taken of a GP’s volume of prescribing of penicillin containing preparations so that doctors who do the most prescribing are not disadvantaged by the indicators. To illustrate this point, in its final form, the indicator might read something like: “the *proportion* of penicillin containing prescriptions by an individual GP (over a given time period) issued to patients with a history of penicillin allergy”.

Please note that for a number of the indicators more than one potential indicator is given if there are variations in wording that we wish to test your views on. For example, one of the indicators relates to the prescription of beta-blockers to patients with a history of asthma. Because some patients with asthma and coronary heart disease are prescribed beta-blockers after initiation by a specialist, a variation of this indicator has been added for patients with “no history of coronary heart disease”.

We have thought carefully about the wording of the indicators, but if you feel that the wording needs to be changed for any indicator, or that an extra nuance needs to be added in, there will be opportunity to bring up any suggestions at the consensus panel meeting. You are welcome to append any comments to the response sheet if you would like to make any views known before the consensus panel meeting.

Tony Avery, June 2009

13. Appendix 3: detailed results from 2nd round of RAND appropriateness method exercise

| Potential indicator | | Detailed panellist rating | | | | | | | | | | | | Agreement (fewer than 3 panelists voting outside 3 point area of median) | |
|---------------------|---|---------------------------|---|---|---|---|---|---|---|---|----|----|----|--|--------------|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | | Median |
| A | Cardiovascular and respiratory disease | | | | | | | | | | | | | | |
| A1(a) | Prescription of a beta-blocker to a patient with asthma | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 8 | 8 | 3 | 7 | 7 | 7 | 3 | 6 | 2 | 8 | 6 | 7 | 7 | Disagreement |
| | <i>Safety of prescribing of individual GPs for <u>the purposes of revalidation</u></i> | 7 | 1 | 3 | 5 | 4 | 3 | 3 | 5 | 6 | 3 | 6 | 5 | 5 | Disagreement |
| A1(b) | Prescription of a non-cardioselective beta-blocker to a patient with asthma | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 8 | 2 | 3 | 7 | 7 | 6 | 1 | 5 | 7 | 9 | 7 | 6 | 7 | Disagreement |
| | <i>Safety of prescribing of individual GPs for <u>the purposes of revalidation</u></i> | 8 | 2 | 3 | 5 | 7 | 6 | 1 | 5 | 6 | 9 | 6 | 5 | 6 | Disagreement |
| A1(c) | Prescription of a beta-blocker to a patient with asthma (<i>excluding patients who also have a cardiac condition, where the benefits of beta-blockers may outweigh the risks</i>) | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 9 | 8 | 9 | 9 | 7 | 9 | 8 | 8 | 7 | 9 | 7 | 9 | 9 | Agreement |
| | <i>Safety of prescribing of individual GPs for <u>the purposes of revalidation</u></i> | 8 | 8 | 9 | 9 | 8 | 7 | 8 | 6 | 7 | 9 | 7 | 9 | 8 | Agreement |
| A2 | Prescription of a nitrate to a patient with aortic stenosis | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 5 | 2 | 2 | 5 | 5 | 7 | 3 | 4 | 4 | 3 | 4 | 1 | 4 | Disagreement |
| | <i>Safety of prescribing of individual GPs for <u>the purposes of revalidation</u></i> | 3 | 2 | 1 | 5 | 4 | 3 | 1 | 4 | 4 | 3 | 3 | 1 | 3 | Disagreement |
| A3 | Prescription of short acting nifedipine in an older person (>65 yrs) (excluding patients with Raynauds disease) | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 6 | 3 | 8 | 5 | 7 | 9 | 6 | 7 | 8 | 7 | 7 | 3 | 7 | Disagreement |
| | <i>Safety of prescribing of individual GPs for <u>the purposes of revalidation</u></i> | 6 | 3 | 7 | 4 | 5 | 7 | 2 | 6 | 7 | 7 | 7 | 3 | 6 | Disagreement |

| Potential indicator | | Detailed panellist rating | | | | | | | | | | | | Agreement (fewer than 3 panelists voting outside 3 point area of median) | |
|---------------------|--|---------------------------|---|---|---|---|---|---|---|---|----|----|----|--|--------------|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | | Median |
| A | Cardiovascular and respiratory disease (continued) | | | | | | | | | | | | | | |
| A3X | Prescription of short acting nifedipine (excluding patients with Raynauds disease) | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 8 | 8 | 8 | 7 | 7 | 9 | 7 | 5 | 8 | 7 | 7 | 3 | 7 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 7 | 8 | 7 | 7 | 7 | 7 | 7 | 5 | 8 | 6 | 7 | 3 | 7 | Agreement |
| A4(a) | In an older person (>65 yrs), prescription of digoxin at a dose of greater than 125 micrograms daily | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 8 | 8 | 9 | 8 | 7 | 9 | 7 | 7 | 8 | 8 | 8 | 7 | 8 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 6 | 8 | 7 | 8 | 7 | 9 | 5 | 5 | 8 | 7 | 8 | 6 | 7 | Disagreement |
| A4(b) | In a patient with renal impairment, prescription of digoxin at a dose greater than 125 micrograms daily (e.g. CKD 3+) | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 8 | 8 | 9 | 9 | 7 | 7 | 7 | 7 | 8 | 8 | 8 | 7 | 8 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 7 | 8 | 7 | 9 | 7 | 7 | 5 | 7 | 8 | 7 | 8 | 6 | 7 | Agreement |
| A5 | Prescription of digoxin at a dose of greater than 125 micrograms daily for a patient with heart failure who is in sinus rhythm | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 8 | 8 | 8 | 9 | 8 | 9 | 8 | 7 | 8 | 8 | 8 | 6 | 8 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 7 | 8 | 7 | 9 | 8 | 9 | 8 | 5 | 8 | 8 | 8 | 6 | 8 | Agreement |
| A6 | Prescription of diltiazem or verapamil in a patient with heart failure | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 7 | 9 | 7 | 7 | 8 | 8 | 6 | 7 | 8 | 7 | 7 | 8 | 7 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 7 | 9 | 7 | 7 | 8 | 8 | 6 | 7 | 7 | 7 | 7 | 8 | 7 | Agreement |
| A7 | In an older patient (>65yrs) the prescription of aspirin at a dose >75mg daily | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 9 | 2 | 6 | 7 | 8 | 9 | 7 | 7 | 9 | 7 | 8 | 6 | 7 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 9 | 2 | 6 | 7 | 8 | 9 | 7 | 7 | 9 | 7 | 8 | 6 | 7 | Agreement |

| Potential indicator | | Detailed panellist rating | | | | | | | | | | | | Agreement (fewer than 3 panellists voting outside 3 point area of median) | |
|---------------------|---|---------------------------|---|---|---|---|---|---|---|---|----|----|----|---|--------------|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | | Median |
| A | Cardiovascular and respiratory disease (continued) | | | | | | | | | | | | | | |
| A7X | In an older patient (>65yrs) the prescription of aspirin at a dose >75mg daily for ≥ one month | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 9 | 2 | 8 | 8 | 8 | 9 | 9 | 7 | 9 | 7 | 8 | 8 | 8 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 9 | 2 | 8 | 8 | 8 | 9 | 9 | 7 | 9 | 7 | 8 | 8 | 8 | Agreement |
| A8 | In a patient with heart failure, the prescription of a high sodium content drug | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 6 | 2 | 4 | 5 | 6 | 6 | 3 | 4 | 4 | 7 | 3 | 1 | 4 | Disagreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 4 | 2 | 2 | 5 | 4 | 3 | 1 | 3 | 3 | 7 | 2 | 1 | 3 | Disagreement |
| A9(a) | In an older patient (>65yrs) with an arrhythmia, the prescription of a tricyclic antidepressant | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 5 | 2 | 3 | 4 | 6 | 4 | 3 | 4 | 6 | 7 | 6 | 3 | 4 | Disagreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 5 | 2 | 2 | 4 | 6 | 3 | 2 | 4 | 3 | 7 | 5 | 2 | 4 | Disagreement |
| A9(b) | In an older patient (>65yrs) with a cardiac conductive abnormality, the prescription of a tricyclic antidepressant | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 5 | 2 | 3 | 4 | 6 | 4 | 3 | 5 | 8 | 7 | 6 | 3 | 4.5 | Disagreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 5 | 2 | 2 | 4 | 6 | 3 | 2 | 4 | 4 | 7 | 5 | 2 | 4 | Disagreement |
| A10 | In a patient with a history of gout, the prescription of a thiazide diuretic | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 6 | 2 | 2 | 4 | 5 | 4 | 6 | 6 | 6 | 8 | 2 | 3 | 4.5 | Disagreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 3 | 2 | 2 | 3 | 3 | 3 | 3 | 5 | 3 | 7 | 2 | 3 | 3 | Agreement |
| A11 | The prescription of a long-acting beta-2 agonist inhaler to a patient with asthma who is not also using an inhaled corticosteroid | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 9 | 9 | 8 | 8 | 9 | 9 | 9 | 8 | 9 | 8 | 8 | 9 | 9 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 9 | 9 | 8 | 8 | 8 | 8 | 8 | 7 | 9 | 8 | 7 | 9 | 8 | Agreement |

| Potential indicator | | Detailed panellist rating | | | | | | | | | | | | Agreement (fewer than 3 panellists voting outside 3 point area of median) | |
|---------------------|---|---------------------------|---|---|---|---|---|---|---|---|----|----|----|---|--------------|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | | Median |
| B | Central nervous system (including analgesics) | | | | | | | | | | | | | | |
| B1(a) | The prescription of aspirin to a child aged 16yrs and under | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 8 | 9 | 9 | 8 | 8 | 8 | 8 | 8 | 9 | 8 | 9 | 9 | 8 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 8 | 9 | 9 | 8 | 7 | 7 | 9 | 8 | 9 | 8 | 9 | 9 | 9 | Agreement |
| B1(b) | The prescription of aspirin to a child aged 16yrs and under, where the child does not have Kawasaki's disease | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 8 | 9 | 8 | 9 | 9 | 9 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 8 | 9 | 8 | 9 | 9 | 9 | Agreement |
| B2 | In a patient with epilepsy, the prescription of a drug that may lower the seizure threshold | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 4 | 2 | 3 | 3 | 6 | 4 | 3 | 6 | 6 | 7 | 5 | 3 | 4 | Disagreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 2 | 2 | 3 | 1 | 4 | 2 | 1 | 3 | 3 | 4 | 4 | 3 | 3 | Agreement |
| B3(a) | In a patient with Parkinson's disease, the prescription of metoclopramide | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 7 | 7 | 8 | 8 | 7 | 9 | 7 | 8 | 9 | 8 | 8 | 9 | 8 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 7 | 7 | 8 | 7 | 7 | 9 | 6 | 8 | 9 | 8 | 8 | 9 | 8 | Agreement |
| B3(b) | In a patient with Parkinson's disease, the prescription of prochlorperazine | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 7 | 7 | 8 | 8 | 7 | 9 | 7 | 8 | 9 | 8 | 8 | 9 | 8 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 7 | 7 | 8 | 7 | 7 | 9 | 6 | 8 | 9 | 8 | 8 | 9 | 8 | Agreement |
| B4(a) | In an older person (>65yrs) the prescription of a benzodiazepine on a long-term basis (i.e. for greater than one month) | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 6 | 8 | 6 | 8 | 7 | 7 | 9 | 6 | 7 | 9 | 7 | 3 | 7 | Disagreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 6 | 2 | 6 | 8 | 4 | 2 | 6 | 5 | 3 | 9 | 4 | 2 | 4.5 | Disagreement |
| B4(a)X | In an older person (>65yrs) the prescription of a benzodiazepine or Z drug on a long-term basis (i.e. for greater than one month) | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 8 | 8 | 7 | 9 | 7 | 8 | 9 | 6 | 7 | 9 | 7 | 4 | 7.5 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 8 | 2 | 8 | 9 | 4 | 3 | 6 | 5 | 3 | 9 | 4 | 3 | 4.5 | Disagreement |

| Potential indicator | | Detailed panellist rating | | | | | | | | | | | | Agreement (fewer than 3 panellists voting outside 3 point area of median) | |
|---------------------|---|---------------------------|---|---|---|---|---|---|---|---|----|----|----|---|--------------|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | | Median |
| B | Central nervous system (including analgesics) (continued) | | | | | | | | | | | | | | |
| B4(b) | In an older person (>65yrs), who is not receiving benzodiazepines on a long-term basis, the prescription of a benzodiazepine for more than 21 days | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 6 | 8 | 6 | 8 | 8 | 6 | 9 | 7 | 9 | 8 | 8 | 9 | 8 | Agreement |
| | <i>Safety of prescribing of individual GPs for <u>the purposes of revalidation</u></i> | 6 | 8 | 6 | 8 | 8 | 7 | 8 | 6 | 8 | 8 | 8 | 9 | 8 | Agreement |
| B4(b)X | In an older person (>65yrs), who is not receiving benzodiazepines or Z drugs on a long-term basis, the prescription of a benzodiazepine or Z drug for more than 21 days | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 8 | 8 | 8 | 9 | 8 | 7 | 9 | 7 | 9 | 8 | 8 | 9 | 8 | Disagreement |
| | <i>Safety of prescribing of individual GPs for <u>the purposes of revalidation</u></i> | 8 | 8 | 8 | 9 | 8 | 9 | 8 | 6 | 8 | 8 | 8 | 9 | 8 | Disagreement |
| B5(a) | In an older person (>65yrs) with depression, the prescription of a long-term benzodiazepine (i.e. greater than 21 days) | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 6 | 8 | 5 | 8 | 7 | 3 | 3 | 7 | 7 | 8 | 8 | 8 | 7 | Disagreement |
| | <i>Safety of prescribing of individual GPs for <u>the purposes of revalidation</u></i> | 6 | 2 | 5 | 8 | 4 | 2 | 3 | 5 | 3 | 8 | 6 | 8 | 5 | Disagreement |
| B5(a)X | In an older person (>65yrs) with depression, the prescription of a long-term benzodiazepine or Z drug (i.e. greater than 21 days) | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 8 | 8 | 8 | 9 | 8 | 6 | 3 | 7 | 7 | 8 | 8 | 9 | 8 | Agreement |
| | <i>Safety of prescribing of individual GPs for <u>the purposes of revalidation</u></i> | 8 | 2 | 8 | 9 | 4 | 6 | 3 | 5 | 3 | 8 | 6 | 9 | 6 | Disagreement |
| B5(b) | In an older person (>65yrs) with depression initiation of benzodiazepine on a long-term basis (i.e. greater than 21 days) | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 7 | 8 | 5 | 8 | 8 | 6 | 8 | 7 | 9 | 8 | 8 | 8 | 8 | Agreement |
| | <i>Safety of prescribing of individual GPs for <u>the purposes of revalidation</u></i> | 7 | 8 | 5 | 8 | 8 | 4 | 6 | 6 | 8 | 8 | 8 | 8 | 8 | Disagreement |
| B5(b)X | In an older person (>65yrs) with depression initiation of benzodiazepine or Z drugs on a long-term basis (i.e. greater than 21 days) | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 9 | 8 | 8 | 9 | 8 | 7 | 8 | 7 | 9 | 8 | 8 | 9 | 8 | Agreement |
| | <i>Safety of prescribing of individual GPs for <u>the purposes of revalidation</u></i> | 8 | 8 | 8 | 9 | 8 | 7 | 6 | 6 | 8 | 8 | 8 | 9 | 8 | Agreement |

| Potential indicator | | Detailed panellist rating | | | | | | | | | | | | Agreement (fewer than 3 panellists voting outside 3 point area of median) | |
|---------------------|--|---------------------------|---|---|---|---|---|---|---|---|----|----|----|--|--------------|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | | Median |
| B | Central nervous system (including analgesics) (continued) | | | | | | | | | | | | | | |
| B6 | In a patient with COPD, the prescription of a benzodiazepine | | | | | | | | | | | | | | Agreement |
| | <i>Safety of prescribing of individual GPs</i> | 5 | 3 | 4 | 4 | 6 | 5 | 5 | 6 | 7 | 7 | 5 | 4 | 5 | |
| | <i>Safety of prescribing of individual GPs for <u>the purposes of revalidation</u></i> | 4 | 3 | 4 | 4 | 4 | 3 | 3 | 4 | 5 | 7 | 4 | 3 | 4 | Disagreement |
| B6X | In a patient with COPD, the prescription of a benzodiazepine or Z drug. | | | | | | | | | | | | | | Disagreement |
| | <i>Safety of prescribing of individual GPs</i> | 3 | 3 | 4 | 4 | 6 | 5 | 5 | 6 | 7 | 7 | 5 | 5 | 5 | |
| | <i>Safety of prescribing of individual GPs for <u>the purposes of revalidation</u></i> | 1 | 3 | 4 | 4 | 4 | 4 | 3 | 4 | 5 | 7 | 4 | 4 | 4 | Disagreement |
| B7(a) | In an older patient (>65yrs) with a history of falls, the prescription of either a benzodiazepine, an antipsychotic or a tricyclic antidepressant | | | | | | | | | | | | | | Disagreement |
| | <i>Safety of prescribing of individual GPs</i> | 7 | 8 | 8 | 7 | 7 | 6 | 4 | 4 | 4 | 7 | 7 | 6 | 7 | |
| | <i>Safety of prescribing of individual GPs for <u>the purposes of revalidation</u></i> | 5 | 4 | 5 | 3 | 3 | 3 | 2 | 3 | 3 | 4 | 5 | 3 | 3 | Disagreement |
| B7(a)X | In an older patient (>65yrs) with a history of falls, the prescription of a benzodiazepine, a Z drug, an antipsychotic or a tricyclic antidepressant | | | | | | | | | | | | | | Disagreement |
| | <i>Safety of prescribing of individual GPs</i> | 7 | 8 | 8 | 7 | 8 | 6 | 4 | 4 | 4 | 7 | 7 | 6 | 7 | |
| | <i>Safety of prescribing of individual GPs for <u>the purposes of revalidation</u></i> | 5 | 4 | 5 | 3 | 3 | 3 | 2 | 3 | 3 | 4 | 5 | 3 | 3 | Disagreement |
| B7(b) | In an older patient (>65yrs) with a history of falls, the prescription of a benzodiazepine | | | | | | | | | | | | | | Disagreement |
| | <i>Safety of prescribing of individual GPs</i> | 7 | 8 | 8 | 7 | 7 | 6 | 4 | 7 | 6 | 7 | 7 | 6 | 7 | |
| | <i>Safety of prescribing of individual GPs for <u>the purposes of revalidation</u></i> | 5 | 4 | 5 | 3 | 3 | 3 | 2 | 5 | 5 | 4 | 5 | 3 | 4 | Disagreement |
| B7(b)X | In an older patient (>65yrs) with a history of falls, the prescription of a benzodiazepine or Z drug. | | | | | | | | | | | | | | Disagreement |
| | <i>Safety of prescribing of individual GPs</i> | 7 | 8 | 8 | 7 | 8 | 6 | 4 | 7 | 6 | 7 | 7 | 6 | 7 | |
| | <i>Safety of prescribing of individual GPs for <u>the purposes of revalidation</u></i> | 5 | 4 | 5 | 3 | 3 | 3 | 2 | 5 | 5 | 4 | 5 | 3 | 4 | Disagreement |

| Potential indicator | | Detailed panellist rating | | | | | | | | | | | | Agreement (fewer than 3 panelists voting outside 3 point area of median) | |
|---------------------|---|---------------------------|---|---|---|---|---|---|---|---|----|----|----|--|--------------|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | | Median |
| B | Central nervous system (including analgesics) (continued) | | | | | | | | | | | | | | |
| B7(c) | In an older patient (>65yrs) with a history of falls, the prescription of an <i>antipsychotic</i> | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 7 | 8 | 8 | 7 | 7 | 6 | 4 | 7 | 8 | 7 | 7 | 3 | 7 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 5 | 4 | 5 | 3 | 3 | 3 | 2 | 5 | 3 | 4 | 5 | 2 | 3.5 | Disagreement |
| B7(d) | In an older patient (>65yrs) with a history of falls, the prescription of a <i>tricyclic antidepressant</i> | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 7 | 8 | 8 | 7 | 7 | 6 | 4 | 5 | 8 | 7 | 7 | 3 | 7 | Disagreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 5 | 4 | 5 | 3 | 3 | 3 | 2 | 5 | 3 | 4 | 5 | 2 | 3.5 | Disagreement |
| B8 | In an older patient (>65yrs) with hyponatraemia/SIADH, the prescription of a selective serotonin reuptake inhibitor | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 7 | 8 | 7 | 7 | 8 | 7 | 4 | 6 | 7 | 7 | 7 | 7 | 7 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 4 | 2 | 3 | 5 | 5 | 5 | 2 | 5 | 5 | 4 | 4 | 3 | 4 | Disagreement |
| B9 | In an older person (>65yrs) with cognitive impairment, the prescription of an antimuscarinic drug | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 7 | 2 | 2 | 5 | 7 | 6 | 5 | 6 | 5 | 7 | 5 | 3 | 5 | Disagreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 6 | 2 | 1 | 4 | 4 | 3 | 3 | 5 | 2 | 4 | 4 | 2 | 3.5 | Disagreement |
| B10 | In a patient with angle closure glaucoma the prescription of an anti-muscarinic drug | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 8 | 2 | 1 | 7 | 6 | 8 | 6 | 6 | 8 | 7 | 7 | 7 | 7 | Disagreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 7 | 2 | 1 | 4 | 6 | 4 | 3 | 4 | 5 | 4 | 5 | 2 | 4 | Disagreement |

| Potential indicator | | Detailed panellist rating | | | | | | | | | | | | Agreement (fewer than 3 panelists voting outside 3 point area of median) | |
|---------------------|---|---------------------------|---|---|---|---|---|---|---|---|----|----|----|---|--------------|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | | Median |
| C | Anti-infective agents | | | | | | | | | | | | | | |
| C1 | Prescription of a tetracycline to a child aged under 12 years | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 8 | 8 | 3 | 7 | 7 | 7 | 3 | 6 | 2 | 8 | 6 | 7 | 7 | Disagreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 7 | 1 | 3 | 5 | 4 | 3 | 3 | 5 | 6 | 3 | 6 | 5 | 5 | Disagreement |
| C2(a) | Prescription of mefloquine to a patient with a history of psychiatric disorder (including depression) | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 8 | 2 | 3 | 7 | 7 | 6 | 1 | 5 | 7 | 9 | 7 | 6 | 7 | Disagreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 8 | 2 | 3 | 5 | 7 | 6 | 1 | 5 | 6 | 9 | 6 | 5 | 6 | Disagreement |
| C2(b) | Prescription of mefloquine to a patient with a history of convulsions | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 9 | 8 | 9 | 9 | 7 | 9 | 8 | 8 | 7 | 9 | 7 | 9 | 9 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 8 | 8 | 9 | 9 | 8 | 7 | 8 | 6 | 7 | 9 | 7 | 9 | 8 | Agreement |
| C2(b)X | Prescription of mefloquine to a patient with a history of epilepsy | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 5 | 2 | 2 | 5 | 5 | 7 | 3 | 4 | 4 | 3 | 4 | 1 | 4 | Disagreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 3 | 2 | 1 | 5 | 4 | 3 | 1 | 4 | 4 | 3 | 3 | 1 | 3 | Disagreement |
| C3 | In an older patient (>65yrs) long-term prescription of nitrofurantoin (i.e. >=28 day prescription) | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 6 | 3 | 8 | 5 | 7 | 9 | 6 | 7 | 8 | 7 | 7 | 3 | 7 | Disagreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 6 | 3 | 7 | 4 | 5 | 7 | 2 | 6 | 7 | 7 | 7 | 3 | 6 | Disagreement |

| Potential indicator | | Detailed panellist rating | | | | | | | | | | | | Agreement (fewer than 3 panellists voting outside 3 point area of median) | |
|---------------------|---|---------------------------|---|---|---|---|---|---|---|---|----|----|----|--|--------------|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | | Median |
| D | Women's health and urinary disorders | | | | | | | | | | | | | | |
| D1 | Prescription of a combined hormonal contraceptive to a women with a history of venous or arterial thromboembolism | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | Agreement |
| D2(a) | Prescription of oral or transdermal oestrogens to a woman with a history of breast cancer | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 9 | 9 | 9 | 9 | 9 | 9 | 8 | 9 | 9 | 9 | 7 | 9 | Agreement | |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 9 | 9 | 9 | 9 | 7 | 8 | 9 | 8 | 9 | 9 | 8 | 5 | 9 | Agreement |
| D2(b) | Prescription of a topical (vaginal) oestrogen to a woman with a history of breast cancer | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 7 | 8 | 7 | 6 | 7 | 7 | 8 | 6 | 6 | 8 | 7 | 5 | 7 | Disagreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 6 | 2 | 5 | 4 | 6 | 3 | 7 | 5 | 3 | 4 | 7 | 5 | 5 | Disagreement |
| D3 | Prescription of oral or transdermal oestrogen without progesterone in a woman with an intact uterus | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 8 | 9 | 8 | 9 | 9 | 9 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 9 | 9 | 9 | 9 | 8 | 9 | 9 | 7 | 9 | 8 | 8 | 9 | 9 | Agreement |
| D4 | Prescription of an antimuscarinic drug to a patient with bladder outflow obstruction | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 7 | 2 | 3 | 4 | 5 | 3 | 3 | 5 | 4 | 8 | 5 | 2 | 4 | Disagreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 5 | 2 | 1 | 3 | 3 | 3 | 1 | 3 | 2 | 4 | 3 | 1 | 3 | Agreement |
| D5X | Prescription of a combined hormonal contraceptive to a woman aged 35 years or older who is a current smoker. | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 9 | 9 | 8 | 9 | 8 | 9 | 8 | 7 | 9 | 8 | 9 | 8 | 8.5 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 9 | 9 | 8 | 9 | 8 | 9 | 8 | 7 | 9 | 8 | 9 | 8 | 8.5 | Agreement |

| Potential indicator | | Detailed panellist rating | | | | | | | | | | | | Agreement (fewer than 3 panelists voting outside 3 point area of median) | |
|---------------------|--|---------------------------|---|---|---|---|---|---|---|---|----|----|----|---|-----------|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | | Median |
| D | Women's health and urinary disorders (continued) | | | | | | | | | | | | | | |
| D6X | Prescription of a combined hormonal contraceptive to a woman with a body mass index of ≥ 40 | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 9 | 9 | 8 | 9 | 8 | 8 | 5 | 7 | 9 | 8 | 9 | 8 | 8 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 9 | 9 | 8 | 9 | 8 | 8 | 3 | 6 | 9 | 8 | 7 | 7 | 8 | Agreement |

| Potential indicator | | Detailed panellist rating | | | | | | | | | | | | Agreement (fewer than 3 panellists voting outside 3 point area of median) | |
|---------------------|---|---------------------------|---|---|---|---|---|---|---|---|----|----|----|--|-----------|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | | Median |
| E | Musculoskeletal | | | | | | | | | | | | | | |
| E1(a) | Prescription of a non-selective NSAID to a patient with a history of peptic ulceration | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 8 | 8 | 7 | 9 | 8 | 7 | 7 | 8 | 9 | 9 | 9 | 8 | 8 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 8 | 8 | 7 | 9 | 7 | 5 | 7 | 8 | 9 | 9 | 9 | 8 | 8 | Agreement |
| E1(a)X | Prescription of an NSAID to a patient with a history of peptic ulceration | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 9 | 9 | 9 | 9 | 8 | 8 | 8 | 8 | 9 | 9 | 9 | 9 | 9 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 9 | 9 | 9 | 9 | 7 | 6 | 8 | 8 | 9 | 9 | 9 | 9 | 9 | Agreement |
| E1(b) | Prescription of a non-selective NSAID to an <i>older</i> patient (>65yrs) with a history of peptic ulceration | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 8 | 8 | 8 | 9 | 9 | 7 | 7 | 8 | 9 | 8 | 9 | 8 | 8 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 8 | 8 | 8 | 9 | 7 | 7 | 7 | 7 | 9 | 8 | 9 | 8 | 8 | Agreement |
| E1(b)X | Prescription of an NSAID to an <i>older</i> patient (>65yrs) with a history of peptic ulceration | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 9 | 9 | 9 | 9 | 9 | 8 | 8 | 8 | 9 | 8 | 9 | 9 | 9 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 9 | 9 | 9 | 9 | 7 | 8 | 8 | 7 | 9 | 8 | 9 | 9 | 9 | Agreement |
| E1(c) | Prescription of a non-selective NSAID, <i>without co-prescription of an ulcer healing drug</i> , to a patient with a history of peptic ulceration | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 8 | 8 | 8 | 9 | 8 | 8 | 6 | 7 | 9 | 9 | 8 | 9 | 8 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 8 | 8 | 8 | 9 | 8 | 7 | 6 | 6 | 9 | 9 | 8 | 9 | 8 | Agreement |
| E1(c)X | Prescription of an NSAID, <i>without co-prescription of an ulcer healing drug</i> , to a patient with a history of peptic ulceration | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 9 | 9 | 9 | 9 | 8 | 9 | 6 | 7 | 9 | 9 | 8 | 9 | 9 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 9 | 9 | 9 | 9 | 8 | 8 | 6 | 6 | 9 | 9 | 8 | 9 | 9 | Agreement |

| Potential indicator | | Detailed panellist rating | | | | | | | | | | | | Agreement (fewer than 3 panelists voting outside 3 point area of median) | |
|---------------------|---|---------------------------|---|---|---|---|---|---|---|---|----|----|----|---|--------------|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | | Median |
| Potential indicator | | Detailed panellist rating | | | | | | | | | | | | Agreement (fewer than 3 panelists voting outside 3 point area of median) | |
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | Median | |
| E | Musculoskeletal (continued) | | | | | | | | | | | | | | |
| E2 | Prescription of a selective COX-2 inhibitor NSAID to a patient with cardiovascular disease (e.g. CHD, cerebrovascular disease or peripheral arterial disease) | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 7 | 3 | 3 | 4 | 7 | 9 | 3 | 7 | 9 | 6 | 4 | 7 | 6.5 | Disagreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 4 | 3 | 1 | 3 | 5 | 5 | 1 | 5 | 3 | 4 | 3 | 3 | 3 | Disagreement |
| E3 | In an older patient (>65yrs), prescription of an NSAID without co-prescription of an ulcer healing drug (e.g. misoprostol or a proton pump inhibitor) | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 8 | 8 | 7 | 9 | 7 | 7 | 5 | 7 | 9 | 7 | 7 | 5 | 7 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 8 | 8 | 3 | 8 | 5 | 7 | 5 | 6 | 4 | 7 | 6 | 5 | 6 | Disagreement |
| E4 | In an older patient (>65yrs), prescription of a long-term (>=28 days), full-dosage longer half-life non-COX-2-selective NSAID | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 5 | 2 | 2 | 5 | 6 | 6 | 1 | 7 | 7 | 4 | 7 | 7 | 5.5 | Disagreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 5 | 2 | 2 | 5 | 4 | 3 | 1 | 5 | 3 | 4 | 7 | 5 | 4 | Disagreement |
| E5 | In an older patient (>65yrs) with heart failure, the prescription of an NSAID | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 8 | 8 | 9 | 8 | 9 | 8 | 7 | 7 | 7 | 7 | 8 | 8 | 8 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 8 | 8 | 9 | 8 | 7 | 8 | 7 | 6 | 8 | 7 | 8 | 7 | 8 | Agreement |
| E5X | In a patient with heart failure, the prescription of an NSAID | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 9 | 9 | 9 | 8 | 9 | 9 | 9 | 7 | 7 | 7 | 8 | 9 | 9 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 9 | 9 | 9 | 8 | 7 | 9 | 9 | 6 | 8 | 7 | 8 | 8 | 8 | Agreement |
| E6 | In an older patient (>65yrs) with chronic renal failure, the prescription of an NSAID (e.g CKD 3 or worse) | | | | | | | | | | | | | | |

| Potential indicator | Detailed panellist rating | | | | | | | | | | | | | Agreement (fewer than 3 panellists voting outside 3 point area of median) |
|--|---------------------------|---|---|---|---|---|---|---|---|----|----|----|--------|--|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | Median | |
| <i>Safety of prescribing of individual GPs</i> | 8 | 8 | 9 | 9 | 8 | 8 | 7 | 7 | 7 | 8 | 8 | 9 | 8 | Agreement |
| <i>Safety of prescribing of individual GPs for <u>the purposes of revalidation</u></i> | 8 | 8 | 9 | 8 | 7 | 8 | 7 | 7 | 8 | 8 | 8 | 9 | 8 | Agreement |

| Potential indicator | | Detailed panellist rating | | | | | | | | | | | | Agreement (fewer than 3 panelists voting outside 3 point area of median) | |
|---------------------|---|---------------------------|---|---|---|---|---|---|---|---|----|----|----|---|--------------|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | | Median |
| E | Musculoskeletal (continued) | | | | | | | | | | | | | | |
| E6X | In a patient with chronic renal failure, the prescription of an NSAID (e.g CKD 3 or worse) | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 9 | 9 | 9 | 9 | 8 | 9 | 9 | 7 | 7 | 8 | 8 | 9 | 9 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 9 | 9 | 9 | 8 | 7 | 9 | 9 | 7 | 8 | 8 | 8 | 9 | 8.5 | Agreement |
| E7 | In an older patient (>65yrs) prescription of a long term (> 28 days) NSAID (except for ibuprofen ≤1200mg daily) | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 8 | 8 | 8 | 8 | 8 | 9 | 8 | 7 | 8 | 8 | 7 | 8 | 8 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 6 | 8 | 7 | 7 | 6 | 7 | 8 | 5 | 7 | 6 | 7 | 7 | 7 | Disagreement |

| Potential indicator | | Detailed panellist rating | | | | | | | | | | | | Agreement (fewer than 3 panelists voting outside 3 point area of median) | |
|---------------------|---|---------------------------|---|---|---|---|---|---|---|---|----|----|----|---|--------------|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | | Median |
| F | Hazardous co-prescriptions, interactions and allergy | | | | | | | | | | | | | | |
| F1 | Prescription of warfarin and aspirin in combination without co-prescription of an ulcer healing drug | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 6 | 2 | 7 | 7 | 6 | 9 | 8 | 8 | 7 | 9 | 8 | 8 | 7.5 | Agreement |
| | <i>Safety of prescribing of individual GPs for <u>the purposes of revalidation</u></i> | 4 | 2 | 3 | 6 | 4 | 6 | 7 | 6 | 3 | 7 | 8 | 6 | 6 | Disagreement |
| F2 | Prescription of warfarin in combination with an oral NSAID | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 9 | 9 | 9 | 7 | 7 | 9 | | 8 | 8 | 8 | 8 | 8 | 8 | Agreement |
| | <i>Safety of prescribing of individual GPs for <u>the purposes of revalidation</u></i> | 9 | 9 | 8 | 7 | 7 | 7 | 6 | 8 | 8 | 8 | 7 | 7 | 7.5 | Agreement |
| F3 | Prescription of a phosphodiesterase type-5 inhibitor, e.g. sildenafil, to a patient who is also receiving a nitrate or nicorandil | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 9 | 8 | 9 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 9 | 8 | Agreement |
| | <i>Safety of prescribing of individual GPs for <u>the purposes of revalidation</u></i> | 9 | 8 | 8 | 8 | 8 | 6 | 6 | 7 | 8 | 6 | 8 | 9 | 8 | Agreement |
| F4(a) | Prescription of clarithromycin or erythromycin to a patient who is also receiving simvastatin | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 7 | 7 | 5 | 7 | 6 | 3 | 6 | 7 | 7 | 7 | 4 | 1 | 6.5 | Disagreement |
| | <i>Safety of prescribing of individual GPs for <u>the purposes of revalidation</u></i> | 7 | 7 | 3 | 6 | 6 | 3 | 5 | 4 | 4 | 7 | 3 | 1 | 4.5 | Disagreement |
| F4(b) | Prescription of clarithromycin or erythromycin to a patient who is also receiving simvastatin, <i>with no evidence that the patient has been advised to stop the simvastatin whilst taking the antibiotic</i> | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 9 | 8 | 8 | 7 | 7 | 6 | 7 | 7 | 7 | 8 | 7 | 8 | 7 | Agreement |
| | <i>Safety of prescribing of individual GPs for <u>the purposes of revalidation</u></i> | 9 | 8 | 8 | 7 | 7 | 6 | 5 | 7 | 7 | 8 | 7 | 8 | 7 | Agreement |

| Potential indicator | | Detailed panellist rating | | | | | | | | | | | | Agreement (fewer than 3 panellists voting outside 3 point area of median) | |
|---------------------|--|---------------------------|---|---|---|---|---|---|---|---|----|----|----|--|--------------|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | | Median |
| F | Hazardous co-prescriptions, interactions and allergy (continued) | | | | | | | | | | | | | | |
| F5(b) | Prescription of a potassium salt or potassium sparing diuretic (excluding aldosterone antagonists such as spironolactone) to a patient who is also receiving an ACE inhibitor or AR-II receptor antagonist | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 9 | 8 | 8 | 8 | 8 | 7 | 7 | 7 | 8 | 8 | 8 | 8 | 8 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 9 | 8 | 8 | 8 | 7 | 6 | 7 | 6 | 8 | 8 | 8 | 8 | 8 | Agreement |
| F6 | Prescription of verapamil to a patient who is also receiving a beta-blocker drug | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 9 | 8 | 9 | 8 | 9 | 6 | 7 | 8 | 7 | 8 | 8 | 8 | 8 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 9 | 8 | 9 | 8 | 7 | 3 | 7 | 7 | 8 | 8 | 8 | 7 | 8 | Agreement |
| F7 | Prescription of quinine to a patient who is also receiving a cardiac glycoside, e.g. digoxin | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 7 | 3 | 3 | 7 | 8 | 6 | 7 | 6 | 7 | 8 | 5 | 5 | 6.5 | Disagreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 5 | 3 | 2 | 7 | 5 | 4 | 5 | 5 | 6 | 8 | 4 | 4 | 5 | Disagreement |
| F8 | Prescription of ciprofloxacin or norfloxacin to a patient who is also receiving theophylline | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 7 | 3 | 4 | 7 | 7 | 7 | 7 | 7 | 7 | 8 | 6 | 3 | 7 | Disagreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 5 | 3 | 4 | 7 | 5 | 5 | 5 | 5 | 5 | 6 | 5 | 3 | 5 | Agreement |
| F9 | Prescription of a penicillin containing preparation to a patient with a history of allergy to penicillin | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 9 | 9 | 9 | 9 | 9 | 9 | 8 | 8 | 9 | 9 | 9 | 9 | 9 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 9 | 9 | 8 | 9 | 7 | 7 | 8 | 8 | 9 | 9 | 8 | 9 | 8.5 | Agreement |
| F10 | Prescription of warfarin and aspirin in combination | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 8 | 8 | 8 | 8 | 8 | 8 | 5 | 8 | 9 | 8 | 8 | 8 | 8 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 4 | 7 | 7 | 7 | 4 | 6 | 2 | 6 | 5 | 8 | 7 | 6 | 6 | Disagreement |

| Potential indicator | | Detailed panellist rating | | | | | | | | | | | | Agreement (fewer than 3 panellists voting outside 3 point area of median) | |
|---------------------|---|---------------------------|---|---|---|---|---|---|---|---|----|----|----|--|--------------|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | | Median |
| G | Laboratory test monitoring | | | | | | | | | | | | | | |
| G1 | Prescription of warfarin to a patient without a record of INR having been measured within the previous 12 weeks | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 7 | 7 | 6 | 8 | 8 | 9 | 8 | 8 | 8 | 7 | 8 | 8 | 8 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 7 | 7 | 6 | 8 | 7 | 8 | 7 | 7 | 8 | 7 | 8 | 7 | 7 | Agreement |
| G1X | Prescription of warfarin to a patient without a record of INR having been measured within the previous 12 weeks (excluding patients who self monitor) | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 8 | 8 | 7 | 9 | 8 | 9 | | 8 | 8 | 7 | 9 | 9 | 8 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 8 | 8 | 7 | 9 | 7 | 9 | | 8 | 8 | 7 | 9 | 8 | 8 | Agreement |
| G2 | Prescription of amiodarone without a record of liver function being measured in the previous six months | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 7 | 3 | 4 | 8 | 7 | 8 | 7 | 6 | 9 | 8 | 6 | 8 | 7 | Disagreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 7 | 3 | 4 | 8 | 7 | 6 | 7 | 7 | 9 | 7 | 6 | 8 | 7 | Disagreement |
| G2X | Prescription of amiodarone without a record of liver function being measured in the previous 9 months | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 8 | 8 | 8 | 9 | 8 | 9 | 8 | 7 | 9 | 8 | 8 | 9 | 8 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 7 | 8 | 8 | 9 | 8 | 9 | 8 | 7 | 9 | 7 | 8 | 9 | 8 | Agreement |
| G3 | Prescription of amiodarone without a record of thyroid function being measured within the previous six months | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 7 | 3 | 4 | 8 | 7 | 8 | 7 | 7 | 9 | 7 | 6 | 8 | 7 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 7 | 3 | 4 | 8 | 7 | 6 | 7 | 7 | 9 | 7 | 6 | 8 | 7 | Disagreement |
| G3X | Prescription of amiodarone without a record of thyroid function being measured within the previous 9 months | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 8 | 8 | 8 | 9 | 8 | 9 | 8 | 7 | 9 | | 8 | 9 | 8 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 7 | 8 | 8 | 9 | 8 | 9 | 8 | 7 | 9 | | 8 | 9 | 8 | Agreement |

| Potential indicator | | Detailed panellist rating | | | | | | | | | | | | Agreement (fewer than 3 panellists voting outside 3 point area of median) | |
|---------------------|--|---------------------------|---|---|---|---|---|---|---|---|----|----|----|--|--------------|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | | Median |
| G | Laboratory test monitoring | | | | | | | | | | | | | | |
| G4 | Prescription of an ACE inhibitor without a record of renal function and electrolytes being measured prior to starting therapy | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 7 | 7 | 9 | 9 | 6 | 7 | 7 | 7 | 9 | 8 | 8 | 9 | 7.5 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 7 | 7 | 9 | 9 | 6 | 7 | 7 | 6 | 9 | 8 | 8 | 9 | 7.5 | Agreement |
| G4X | Prescription of an ACE inhibitor or ARB without a record of renal function and electrolytes being measured prior to starting therapy | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 8 | 8 | 9 | 9 | 8 | 7 | 8 | 7 | 9 | 8 | | 9 | 8 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 8 | 8 | 9 | 9 | 7 | 7 | 8 | 6 | 9 | 8 | | 9 | 8 | Agreement |
| G5(a) | Prescription of lithium without a record of a lithium level being measured within the previous three months | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 8 | 6 | 7 | 8 | 7 | 6 | 4 | 7 | 9 | 8 | 6 | 3 | 7 | Disagreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 8 | 6 | 7 | 8 | 7 | 3 | 4 | 6 | 9 | 8 | 6 | 3 | 6.5 | Disagreement |
| G5(b) | Prescription of lithium without a record of a lithium level being measured within the previous six months | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 8 | 8 | 8 | 9 | 8 | 9 | 7 | 7 | 9 | 7 | 8 | 9 | 8 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 8 | 8 | 8 | 9 | 6 | 8 | 7 | 7 | 9 | 7 | 8 | 9 | 8 | Agreement |
| G6 | Prescription of methotrexate without a record of a full blood count within the previous three months | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 9 | 8 | 6 | 8 | 9 | 9 | 8 | 8 | 9 | 8 | 8 | 8 | 8 | Agreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 9 | 8 | 6 | 8 | 8 | 9 | 8 | 8 | 9 | 8 | 8 | 8 | 8 | Agreement |
| G6X | Prescription of methotrexate without a record of a full blood count within the previous 4 months | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 9 | 7 | 9 | 9 | 6 | 6 | 6 | 5 | 6 | 8 | 7 | 9 | 7 | Disagreement |
| | <i>Safety of prescribing of individual GPs for the purposes of revalidation</i> | 9 | 7 | 9 | 9 | 5 | 6 | 6 | 5 | 6 | 8 | 7 | 9 | 7 | Disagreement |

| Potential indicator | | Detailed panellist rating | | | | | | | | | | | | Agreement (fewer than 3 panellists voting outside 3 point area of median) | |
|---------------------|---|---------------------------|---|---|---|---|---|---|---|---|----|----|----|--|--------------|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | | Median |
| G | Laboratory test monitoring | | | | | | | | | | | | | | |
| G7 | Prescription of methotrexate without a record of liver function having been measured within the previous three months | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 9 | 8 | 6 | 8 | 9 | 9 | 8 | 8 | 9 | 7 | 8 | 8 | 8 | Agreement |
| | <i>Safety of prescribing of individual GPs for <u>the purposes of revalidation</u></i> | 9 | 8 | 6 | 8 | 8 | 9 | 8 | 8 | 9 | 7 | 8 | 8 | 8 | Agreement |
| G7X | Prescription of methotrexate without a record of liver function having been measured within the previous 4 months | | | | | | | | | | | | | | |
| | <i>Safety of prescribing of individual GPs</i> | 9 | 7 | 9 | 9 | 6 | 6 | 6 | 5 | 6 | 6 | 7 | 9 | 6.5 | Disagreement |
| | <i>Safety of prescribing of individual GPs for <u>the purposes of revalidation</u></i> | 9 | 7 | 9 | 9 | 5 | 6 | 6 | 5 | 6 | 6 | 7 | 9 | 6.5 | Disagreement |