

Quality and Outcomes Framework guidance for 2024/25

1 April 2024



Contents

1. Introduction	1
1.1 Purpose of this document	1
1.2 Definition of ‘commissioner’	1
1.3 Additional indicator information	2
1.4 Reporting, payment calculation and verification	3
1.5 Disputes	5
2. Summary of all indicators	6
2.1 Income protected indicators (212 points)	6
2.2 Clinical domain (401 points)	11
2.3 Public health domain (160 points)	22
2.4 Public health domain – additional services sub-domain	23
2.5 Quality improvement domain (74 points)	24
3. Clinical domain	24
3.1 Atrial fibrillation (AF)	24
3.2 Secondary prevention of coronary heart disease (CHD)	29
3.3 Cholesterol control and lipid management (CHOL)	32
3.4 Heart failure (HF)	35
3.5 Hypertension (HYP)	40
3.6 Peripheral arterial disease (PAD)	43
3.7 Stroke and TIA (STIA)	44
3.8 Diabetes mellitus (DM)	48
3.9 Asthma (AST)	58
3.10 Chronic obstructive pulmonary disease (COPD)	67
3.11 Dementia (DEM)	71
3.12 Depression (DEP)	76
3.13 Mental health (MH)	79
3.14 Cancer (CAN)	87
3.15 Chronic kidney disease (CKD)	91
3.16 Epilepsy (EP)	93

3.17	Learning disabilities (LD)	94
3.18	Osteoporosis: secondary prevention of fragility fractures (OST)	98
3.19	Rheumatoid arthritis (RA)	101
3.20	Palliative care (PC)	104
3.21	Non-diabetic hyperglycaemia (NDH)	106
4.	Public health domain	109
4.1	Blood pressure (BP)	109
4.2	Obesity (OB)	110
4.3	Smoking (SMOK)	112
4.4	Vaccination and immunisations (VI)	116
	Public health domain – additional services	124
4.5	Cervical screening (CS)	124
5.	Quality improvement domain	126
6.	Personalised care adjustments	127
7.	Glossary of acronyms	135
8.	Queries	141

1. Introduction

1.1 Purpose of this document

- i. This document provides additional guidance on the interpretation and verification of the QOF indicators for **2024/25** in England, which are listed in Annex D of the Statement of Financial Entitlements Directions (SFE)¹. It is effective from 1 April **2024** and replaces versions issued in previous years.
- ii. This document covers:
 - Section 2: the list of QOF indicators as detailed in Annex D of the SFE Directions
 - Section 3: specific information about each clinical indicator including the rationale for inclusion and any specific requirements which contractors need to demonstrate to ensure achievement
 - Section 4: specific information about each public health indicator including the rationale for inclusion and any specific requirements which contractors need to demonstrate to ensure achievement
 - Section 5: detailed information about the requirements of the quality improvement domain
 - Section 6: detailed information about personalised care adjustments
 - Section 7: glossary of acronyms
 - Section 8: the process for raising queries in relation to QOF indicators and their interpretation
- iii. This guidance should be read in conjunction with the SFE Directions and [business rules](#).

1.2 Definition of 'commissioner'

- i. NHS England is the organisation legally responsible for the commissioning of primary care in England. Following the implementation of delegated commissioning references to 'commissioners' in this document could refer to NHS England or, since 1 July 2022, Integrated Care Boards (ICBs)

¹ <https://www.gov.uk/government/publications/nhs-primary-medical-services-directions-2013>

1.3 Additional indicator information

- i. Full descriptions of each indicator, its rationale for inclusion and any specific criteria for reporting and verification are detailed in Sections 3, 4 and 5.

Clinical and public health indicators

- i. Clinical and public health indicators are organised by disease or intervention categories. These indicators have been selected as they represent care where:
 - the responsibility for ongoing management rests principally with the contractor and the primary care team
 - there is good evidence of the health benefits likely to result from improved primary care

Indicator numbering

- i. Indicators are prefixed with an abbreviation of the category to which they belong. For example, coronary heart disease indicator one is identified as CHD001. Indicator IDs are unique to each indicator and are not reused. New indicators will be given the next available unused number. Therefore, this may not flow sequentially from the existing indicator IDs. Similarly, where there has been a change to indicator wording, activity timescales or significant changes to coding or the data extraction logic these indicators will be given a new unique ID. This is to ensure that indicators are not inappropriately compared to those in previous years and to avoid any confusion which could arise from re-using ID numbers.
- ii. Where an indicator has been developed through the NICE led process² they will also be annotated with their NICE menu ID number (NICE [year] menu ID: NMXX). If a NICE developed indicator has been amended during negotiations this will be annotated with 'based on NMXX'. References to NICE guidance throughout this document relate to the guidance that has been used to underpin the stated indicators. In some cases, new or updated guidance may have been recently published, or will be published before the end of the QOF year. These guidelines will be reviewed by NICE in due course and any recommendations concerning amending current indicators or development of new indicators will be published in future NICE indicator menus for consideration by relevant parties.

² <https://www.nice.org.uk/standards-and-indicators/indicators>

Identifying the target population or disease register

- i. Clinical indicators all have a defined target population. This may be defined within a register indicator or as part of the business rules. This target population will be identified either by the presence of predetermined clinical diagnosis codes in the patient record or by using other attributes of the patient such as age and sex. For example, the target population for cervical screening is constructed using age and sex to determine inclusion in the denominator for each indicator. Where the target population is identified using clinical codes the contractor is responsible for demonstrating that it has systems in place to maintain a high quality, accurate register. This may be verified by the commissioner and contractors may be asked to explain reasons for variation from expected prevalence levels. Contractors are reminded that QOF registers must not be used as the sole input for the purposes of patient care and clinical audit. There may be patients for whom a treatment or activity is clinically appropriate, but they may not meet the criteria as defined by the QOF register. Contractors are asked to hold this in mind when developing call/recall systems.
- ii. Patients with co-morbidities will be included in all relevant target populations and registers where they meet the defined criteria. Where a patient is in more than one target population, they are eligible for the interventions outlined in all relevant disease areas.
- iii. Some indicators refer to a sub-set of patients in the target population or register. Patients who are not included in an indicator denominator for definitional reasons are classified as 'exclusions' and are automatically identified through the business rules and removed from the denominator.
- iv. Patients are eligible for the interventions outlined in QOF indicators as soon as they are fully registered with the contractor, or a relevant diagnosis is recorded.
- v. Where a practice does not have registered patients within a particular cohort, no specific care interventions are needed and so QOF points will not be earnable.

1.4 Reporting, payment calculation and verification

Reporting

- i. Reporting requirements and the rules for the calculation of QOF points and their payment are set out in the SFE. For most indicators anonymised data

will be collected automatically from GP clinical systems by the General Practice Extraction Service (GPES) and reported to the Calculating Quality Reporting Service (CQRS).

- ii. The clinical codes and logical extraction sequence used in this data collection is defined in a series of technical documents – the business rules. These are based entirely on SNOMED codes and associated dates, combined with patient characteristics (e.g. age and sex). SNOMED codes are an NHS standard. Contractors using proprietary coding systems and/or local/practice specific codes will need to be aware that these codes will not be recognised within QOF reporting. The business rules are available on the NHS Digital website.
- iii. For indicators where achievement is not automatically collected this should be self-declared through the CQRS website. Commissioners may request evidence underpinning this self-declaration as part of their verification processes.

Payment calculation and achievement

- i. CQRS will calculate achievement and payments for QOF as set out in the SFE and report to commissioners and practices. Whilst full details of the achievement calculations are detailed in the SFE, the following key points are useful to note:
 - Achievement is measured on the last day of the financial year (i.e. 31 March) in respect of patients registered with the practice on that date. Whilst estimates of achievement may be made through the year, these may not accurately predict final performance.
 - The time period referred to in an indicator is calculated by counting back from the last day of the financial year. Time periods vary between indicators.
 - The phrase ‘currently treated’ should be interpreted as a prescription for the specified medication being given in the six months preceding the last day of the financial year (i.e. between 1 October and 31 March).
 - Some indicators require the intervention to be offered to patients when they reach a defined age or within a specified time before and/or after diagnosis. Care recorded outside of these time periods will not be recognised in the QOF achievement calculation.
- ii. There are specific provisions within the SFE which describe the calculations to be made where a contract comes to an end before the last day of the financial year.

Verification

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- i. The contractor must ensure that it is able to provide any information that the NHSE or ICB may reasonably request of it to demonstrate that it is entitled to each achievement point to which it says it is entitled. The contractor must make that information available to the commissioner on request. In verifying that an indicator has been achieved and information correctly recorded, the commissioner may choose to inspect the output from a computer search that has been used to provide information on the indicator, or a sample of patient records relevant to the indicator.
 - ii. Commissioners and practices will be aware of the requirements of access to patient identifiable data, in particular that they should:
 - obtain the minimum necessary information for the specific purpose
 - anonymise data where possible
 - iii. Where patients have expressed a desire that their information is not shared for this purpose, practices will need to advise the commissioner and make an appropriate note in the record. It is recommended that practices record access to confidential patient data in the relevant patient record, so that an audit trail is in place to fulfil the obligations of the practice towards their patients and that of commissioners to practices.
 - iv. The terms 'notes' and 'patient record' are used to indicate either electronic or paper patient records.

1.5 Disputes

When a QOF related contractual dispute arises, the commissioner and contractor would be expected to make every reasonable effort to communicate and co-operate with each other with a view to resolving the dispute without the need to refer it for formal determination by NHS Resolution (Primary Care Appeals) (or in certain cases, the courts). Further information is available in the SFE.

2. Summary of all indicators

2.1 Income protected indicators (212 points)

- i. NHS England has income protected an increased number of indicators for 2024/25. Building upon the income protection of the disease register indicators within QOF for 2023/24, a further 13 indicators will be subject to income protection in the 2024/25 QOF, bringing the total to 32. This includes 19 register indicators, 6 clinical indicators, 1 public health indicator and 6 quality improvement indicators. These 32 indicators have a total of 212 points assigned to them, which is a third of the total points available within QOF.
- ii. For the indicators that are income protected, practices will have their 2024/25 achievement in points set at the same level as that achieved in 2023/24. It should be noted that this means practices will not be penalised for falling performance within the income protected indicators, but neither will they be rewarded for improvements in those indicators.
- iii. Income protection does not mean that the payment amount will be the same in 2024/25 as in 2023/24. QOF earnings will continue to be subject to prevalence adjustments, list size variation, with these being based on 2024/25 figures. Therefore, the final payment amount may be different.
- iv. Practices will continue to be expected to maintain the registers and accurately code patient records with up-to-date information on diagnoses, as this activity performs an important role in maintaining clinical quality. There will continue to be a GPES extract of diagnosis which is used to calculate prevalence adjustments for indicators. Failure to maintain the registers will have an impact on prevalence adjustments and therefore will impact on practice income at the end of the financial year.
- v. Where practices open, close or merge between 2023/24 and 2024/25 achievement will be calculated as below:
 - a. For practices merging, the combined 2023/24 performance, list and prevalence data for the practices that merged will be used to calculate new practice data that can be used in 2024/25. In some cases, the merging may be complex enough that this is not possible. In this case, we propose using the higher performance of the original practices or 2024/25 data for list and prevalence adjustments.
 - b. Practices splitting into multiple practices will be paid based on the 2023/24 performance of the practice they were created from. 2024/25 list and 2024/25 prevalence adjustments will be used.

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- c. New practices will be paid based on actual performance in 2024/25, using list and practice adjustments from 2024/25.
- vi. For situations that are not covered by the above, commissioners, informed by working with the practice, will determine the most appropriate way of calculating achievement for the income protected points.
- vii. When dealing with practices mergers, opening and closing practices commissioners and practices should refer to the [Primary Medical Care Policy and Guidance Manual](#).
- viii. The Income protected points for the indicators set out in the Summary of Indicators in Annex D of the Statement of Financial Entitlements (SFE) are available as follows:
- The points available for an indicator are set out in the second column of the Summary of Indicators in Annex D.
 - The income protected indicators are noted clearly in the table in Section 2.1 in the Summary of Indicators of Annex D;
 - The income protected indicators are the disease register indicators, noted clearly in the Summary of Indicators of Annex D.

Indicator ID	Indicator	Points
AF001	The contractor establishes and maintains a register of patients with atrial fibrillation.	5
CHD001	The contractor establishes and maintains a register of patients with coronary heart disease.	4
HF001	The contractor establishes and maintains a register of patients with heart failure.	4
HYP001	The contractor establishes and maintains a register of patients with established hypertension.	6
PAD001	The contractor establishes and maintains a register of patients with peripheral arterial disease.	2
STIA001	The contractor establishes and maintains a register of patients with stroke or TIA.	2
DM017	The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed.	6
AST005	The contractor establishes and maintains a register of patients with asthma aged 6 years or over, excluding patients with asthma who have been prescribed no asthma related drugs in the preceding 12 months.	4
COPD015	<p>The contractor establishes and maintains a register of:</p> <ol style="list-style-type: none"> 1. Patients with a clinical diagnosis of COPD before 1 April 2023 and 2. Patients with a clinical diagnosis of COPD on or after 1 April 2023 whose diagnosis has been confirmed by a quality assured post bronchodilator spirometry FEV1/FVC ratio below 0.7 between 3 months before and 6 months after diagnosis (or if newly registered at the practice in the preceding 12 months a record of an FEV1/FVC ratio below 0.7 recorded within 6 months of registration); and 	8

	3. Patients with a clinical diagnosis of COPD on or after 1 April 2023 who are unable to undertake spirometry.	
DEM001	The contractor establishes and maintains a register of patients diagnosed with dementia.	5
MH001	The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy.	4
CAN001	The contractor establishes and maintains a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers diagnosed on or after 1 April 2003'.	5
CKD005	The contractor 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).	6
EP001	The contractor establishes and maintains a register of patients aged 18 or over receiving drug treatment for epilepsy.	1
LD004	The contractor establishes and maintains a register of patients with learning disabilities.	4
OST004	The contractor establishes and maintains a register of patients: <ol style="list-style-type: none"> 1. Aged 50 or over and who have not attained the age of 75 with a record of a fragility fracture on or after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and 2. Aged 75 or over with a record of a fragility fracture on or after 1 April 2014 and a diagnosis of osteoporosis. 	3
RA001	The contractor establishes and maintains a register of patients aged 16 or over with rheumatoid arthritis.	1
PC001	The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age.	3

OB003	The contractor establishes and maintains a register of patients aged 18 years or over living with obesity, appropriately adjusted for ethnicity in line with NICE guidelines – either with a BMI ≥ 30 in the preceding 12 months, or a BMI greater than or equal to 27.5 kg/m ² recorded in the preceding 12 months for patients with a South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean family background.	8
AST008	The percentage of patients with asthma on the register aged 19 or under, in whom there is a record of either personal smoking status or exposure to second-hand smoke in the preceding 12 months.	6
COPD014	The percentage of patients with COPD and Medical Research Council (MRC) dyspnoea scale ≥ 3 at any time in the preceding 12 months, with a subsequent record of referral to a pulmonary rehabilitation programme (excluding those who have previously attended a pulmonary rehabilitation programme).	2
MH021	Percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who received all six elements of the Physical Health Check for people with Severe Mental Illness.	6
DEP004	The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis.	10
SMOK005	The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 months.	25

CAN004	The percentage of patients with cancer, diagnosed within the preceding 24 months, who have a patient Cancer Care Review using a structured template recorded as occurring within 12 months of the date of diagnosis.	6
CAN005	The percentage of patients with cancer, diagnosed within the preceding 12 months, who have had the opportunity for a discussion and informed of the support available from primary care, within 3 months of diagnosis.	2
QI domain	This includes the former QI indicators; QI013, QI014, QI016, QI017, QI018 and QI019	74

2.2 Clinical domain (401 points)

This domain applies to all contractors participating in QOF.

Income protected register indicators are shaded grey for clarity.

Atrial fibrillation (AF)	Points	Thresholds
Records		
AF001. The contractor establishes and maintains a register of patients with atrial fibrillation	5	N/A

Ongoing management		
AF006. The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA ₂ DS ₂ -VASc score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous CHADS ₂ or CHA ₂ DS ₂ -VAS _c score of 2 or more)	12	40-90%
AF008. Percentage of patients on the QOF Atrial Fibrillation register and with a CHA ₂ DS ₂ -VASc score of 2 or more, who were prescribed a direct-acting oral anticoagulant (DOAC), or, where a DOAC was declined or clinically unsuitable, a Vitamin K antagonist	12	70-95%
Secondary prevention of coronary heart disease (CHD)	Points	Thresholds
Records		
CHD001. The contractor establishes and maintains a register of patients with coronary heart disease	4	N/A
Ongoing management		
CHD005. The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken	7	56–96%
CHD015. The percentage of patients aged 79 years or under, with coronary heart disease, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less, (or equivalent home blood pressure reading)	12	40-77%
CHD016. The percentage of patients aged 80 years or over, with coronary heart disease, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less, (or equivalent home blood pressure reading)	5	46-86%
Heart failure (HF)	Points	Thresholds
Records		

HF001. The contractor establishes and maintains a register of patients with heart failure	4	N/A
Initial diagnosis		
HF008. The percentage of patients with a diagnosis of heart failure on or after 1 April 2023 which: 1. Has been confirmed by an echocardiogram or by specialist assessment in the 6 months before entering on to the register; or 2. If registered at the practice after diagnosis, with no record of the diagnosis originally being confirmed either by echocardiogram or by specialist assessment, a record of an echocardiogram or a specialist assessment within 6 months of the date of registration.	6	50–90%
Ongoing management		
HF003. In those patients with a diagnosis of heart failure due to left ventricular systolic dysfunction or whose heart failure is due to reduced ejection fraction the percentage of patients who are currently treated with an angiotensin-converting enzyme inhibitor (ACE-I) or Angiotensin II receptor blockers (ARB)	6	60–92%
HF006. The percentage of patients with a diagnosis of heart failure due to left ventricular systolic dysfunction or whose heart failure is due to reduced ejection fraction, who are currently treated with a beta-blocker licensed for heart failure	6	60-92%
HF007. The percentage of patients with a diagnosis of heart failure on the register, who have had a review in the preceding 12 months, including an assessment of functional capacity and a review of medication to ensure medicines optimisation at maximal tolerated doses	7	50-90%
Hypertension (HYP)	Points	Thresholds
Records		
HYP001. The contractor establishes and maintains a register of patients with established hypertension	6	N/A
Ongoing management		

HYP008. The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (or equivalent home blood pressure reading)	14	40-77%
HYP009. The percentage of patients aged 80 years or over, with hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less, (or equivalent home blood pressure reading)	5	40-80%
Peripheral arterial disease (PAD)	Points	Thresholds
Records		
PAD001. The contractor establishes and maintains a register of patients with peripheral arterial disease	2	N/A
Stroke and transient ischaemic attack (STIA)	Points	Thresholds
Records		
STIA001. The contractor establishes and maintains a register of patients with stroke or TIA	2	N/A
Ongoing management		
STIA007. The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 12 months that an anti-platelet agent, or an anti-coagulant is being taken	4	57-97%
STIA014. The percentage of patients aged 79 years or under, with a history of stroke or TIA, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (or equivalent home blood pressure reading)	3	40-73%
STIA015. The percentage of patients aged 80 years or over, with a history of stroke or TIA, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less, (or equivalent home blood pressure reading)	2	46-86%
Cholesterol control and lipid management (CHOL)	Points	Thresholds
Ongoing management		

CHOL003. Percentage of patients on the QOF Coronary Heart Disease, Peripheral Arterial Disease, Stroke/TIA or Chronic Kidney Disease Register who are currently prescribed a statin, or where a statin is declined or clinically unsuitable, another lipid-lowering therapy	14	70-95%
CHOL004. Percentage of patients on the QOF Coronary Heart Disease (CHD), Peripheral Arterial Disease (PAD), or Stroke/ Transient Ischaemic Attack (TIA) Register, who have a recording of LDL (Low-density Lipoprotein) cholesterol in the preceding 12 months that is 2.0 mmol/L or lower or where LDL cholesterol is not recorded a recording of non-HDL (High-density Lipoprotein) cholesterol in the preceding 12 months that is 2.6 mmol/L or lower	16	20-35%
Diabetes mellitus (DM)	Points	Thresholds
Records		
DM017. The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed	6	N/A
Ongoing management		
DM006. The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs)	3	57–97%
DM012. The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 12 months	4	50–90%
DM014. The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register	11	40–90%

DM020. The percentage of patients with diabetes, on the registers, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months	17	35-75%
DM021. The percentage of patients with diabetes, on the register, with moderate or severe frailty in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months	10	52-92%
DM022. The percentage of patients with diabetes aged 40 years and over, with no history of cardiovascular disease and without moderate or severe frailty, 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)	4	50-90%
DM023. The percentage of patients with diabetes and a history of cardiovascular disease (excluding haemorrhagic stroke) who are currently treated with a statin	2	50-90%
DM033. The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (or equivalent home blood pressure reading)	10	38-78%
Asthma (AST)	Points	Thresholds
Records		
AST005. The contractor establishes and maintains a register of patients with asthma aged 6 years or over, excluding patients with asthma who have been prescribed no asthma related drugs in the preceding 12 months	4	N/A
Initial diagnosis		

AST011. The percentage of patients with a diagnosis of asthma on or after 1 April 2023 with either: 1. A record of quality assured spirometry and one other objective test (FeNO or, bronchodilator reversibility or peak flow variability) between 3 months before or 6 months after diagnosis; or 2. If newly registered in the preceding 12 months with a diagnosis of asthma recorded on or after 1 April 2023 but no record of objective tests being performed at the date of the registration, with a quality assured spirometry and one other objective test (FeNO or bronchodilator reversibility or peak flow variability) recorded within 6 months of the registration	15	45–80%
Ongoing management		
AST007. The percentage of patients with asthma on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using a validated asthma control questionnaire, a recording of the number of exacerbations, an assessment of inhaler technique and a written personalised action plan	20	45–70%
AST008. The percentage of patients with asthma on the register aged 19 or under, in whom there is a record of either personal smoking status or exposure to second-hand smoke in the preceding 12 months	6	45–80%
Chronic obstructive pulmonary disease (COPD)	Points	Thresholds
Records		
COPD015. The contractor establishes and maintains a register of: 1. Patients with a clinical diagnosis of COPD before 1 April 2023; and 2. Patients with a clinical diagnosis of COPD on or after 1 April 2023 whose diagnosis has been confirmed by a quality assured post-bronchodilator spirometry FEV1/FVC ratio below 0.7 between 3 months before or 6 months after diagnosis (or if newly registered at the practice in the preceding 12 months without a record of spirometry having been performed, a record of an FEV1/FVC ratio below 0.7 recorded within 6 months of registration); and	8	N/A

3. Patients with a clinical diagnosis of COPD on or after 1 April 2023 who are unable to undertake spirometry		
Ongoing management		
COPD010. The percentage of patients with COPD on the register, who have had a review in the preceding 12 months, including a record of the number of exacerbations and an assessment of breathlessness using the Medical Research Council dyspnoea scale	9	50–90%
COPD014. The percentage of patients with COPD and Medical Research Council (MRC) dyspnoea scale ≥ 3 at any time in the preceding 12 months, with a subsequent record of referral to a pulmonary rehabilitation programme (excluding those who have previously attended a pulmonary rehabilitation programme)	2	40-90%
Dementia (DEM)	Points	Thresholds
Records		
DEM001. The contractor establishes and maintains a register of patients diagnosed with dementia	5	N/A
Ongoing management		
DEM004. The percentage of patients diagnosed with dementia whose care plan has been reviewed in the preceding 12 months	14	35–70%
Depression (DEP)	Points	Thresholds
Initial management		

DEP004. The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis	10	45–80%
Mental health (MH)	Points	Thresholds
Records		
MH001. The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy	4	N/A
Ongoing management		
MH002. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate	5	40–90%
MH003. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months	3	50–90%
MH006. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months	3	50-90%
MH007. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months	3	50-90%
MH011. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of a lipid profile in the preceding 12 months (in those patients currently prescribed antipsychotics, and/or have pre-existing cardiovascular conditions, and/or smoke, and/or are overweight (BMI of ≥ 23 kg/m ² or ≥ 25 kg/m ² if ethnicity is recorded as White)) or preceding 24 months for all other patients	7	50-90%
MH012. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months	7	50-90%

MH021: Percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who received all six elements of the Physical Health Check for people with Severe Mental Illness	6	50-80%
Cancer (CAN)	Points	Thresholds
Records		
CAN001. The contractor establishes and maintains a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers diagnosed on or after 1 April 2003'	5	N/A
Ongoing management		
CAN004. The percentage of patients with cancer, diagnosed within the preceding 24 months, who have a patient Cancer Care Review using a structured template recorded as occurring within 12 months of the date of diagnosis	6	50–90%
CAN005. The percentage of patients with cancer, diagnosed within the preceding 12 months, who have had the opportunity for a discussion and informed of the support available from primary care, within 3 months of diagnosis	2	70-90%
Chronic kidney disease (CKD)	Points	Thresholds
Records		
CKD005. The contractor 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)	6	N/A
Epilepsy (EP)	Points	Thresholds
Records		
EP001. The contractor establishes and maintains a register of patients aged 18 or over receiving drug treatment for epilepsy	1	N/A
Learning disability (LD)	Points	Thresholds

Records		
LD004. The contractor establishes and maintains a register of patients with learning disabilities	4	N/A
Osteoporosis: secondary prevention of fragility fractures (OST)	Points	Thresholds
Records		
OST004. The contractor establishes and maintains a register of patients: 1. Aged 50 or over and who have not attained the age of 75 with a record of a fragility fracture on or after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and 2. Aged 75 or over with a record of a fragility fracture on or after 1 April 2014 and a diagnosis of osteoporosis	3	N/A
Rheumatoid arthritis (RA)	Points	Thresholds
Records		
RA001. The contractor establishes and maintains a register of patients aged 16 or over with rheumatoid arthritis	1	N/A
Palliative care (PC)	Points	Thresholds
Records		
PC001. The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age	3	N/A
Non diabetic hyperglycaemia (NDH)	Points	Thresholds
Records		
NDH002. The percentage of patients with non-diabetic hyperglycaemia who have had an HbA1c or fasting blood glucose performed in the preceding 12 months	18	50–90%

2.3 Public health domain (160 points)

This domain applies to all contractors participating in QOF, with the exception of the additional services sub-domain (discussed below).

Blood pressure (BP)	Points	Thresholds
BP002. The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years	15	50–90%
Obesity (OB)	Points	Thresholds
Records		
OB003. The contractor establishes and maintains a register of patients aged 18 years or over living with obesity, appropriately adjusted for ethnicity in line with NICE guidelines – either with a BMI greater than or equal to 30 kg/m ² recorded in the preceding 12 months, or a BMI greater than or equal to 27.5 kg/m ² recorded in the preceding 12 months for patients with a South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean family background	8	N/A
Smoking (SMOK)	Points	Thresholds
Records		
SMOK002. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months	25	50–90%
Ongoing management		
SMOK004. The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 24 months	12	40–90%

SMOK005. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 months	25	56–96%
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Vaccination and Immunisations (VI)	Points	Thresholds
VI001. The percentage of babies who reached 8 months old in the preceding 12 months, who have received at least 3 doses of a diphtheria, tetanus and pertussis containing vaccine before the age of 8 months	18	89-96%
VI002. The percentage of children who reached 18 months old in the preceding 12 months, who have received at least 1 dose of MMR between the ages of 12 and 18 months	18	86-96%
VI003. The percentage of children who reached 5 years old in the preceding 12 months, who have received a reinforcing dose of DTaP/IPV and at least 2 doses of MMR between the ages of 1 and 5 years	18	81-96%
VI004. The percentage of patients who reached 80 years old in the preceding 12 months, who have received a shingles vaccine between the ages of 70 and 79 years	10	50-60%

2.4 Public health domain – additional services sub-domain

The additional services sub-domain applies to contractors who provide additional services under the terms of the GMS contract and participate in QOF.

Cervical screening (CS)	Points	Thresholds
CS005. The proportion of women eligible for screening and aged 25-49 years at the end of period reported whose notes record that an adequate cervical screening test has been performed in the previous 3 years and 6 months	7	45-80%
CS006. The proportion of women eligible for screening and aged 50-64 years at the end of period reported whose notes record that an adequate cervical screening test has been performed in the previous 5 years and 6 months	4	45-80%

2.5 Quality improvement domain (74 points)

This domain applies to all contractors participating in QOF.

Workforce and Wellbeing	Points	Thresholds
The QI domain which formerly included QI013, QI014, QI016, QI017, QI018 and QI019	74	N/A

3. Clinical domain

3.1 Atrial fibrillation (AF)

Indicator	Points	Thresholds
Records		
AF001. The contractor establishes and maintains a register of patients with atrial fibrillation	5	N/A
Ongoing management		

AF006. The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA ₂ DS ₂ -VASc score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous CHADS ₂ or CHA ₂ DS ₂ -VASc score of 2 or more)	12	40-90%
AF008. Percentage of patients on the QOF Atrial Fibrillation register and with a CHA ₂ DS ₂ -VASc score of 2 or more, who were prescribed a direct-acting oral anticoagulant (DOAC), or, where a DOAC was declined or clinically unsuitable, a Vitamin K antagonist	12	70-95%

AF – rationale for inclusion of indicator set

- i. AF is the most common heart rhythm disorder, affecting approximately 2% of the adult population, and estimates suggest its prevalence is increasing. AF causes palpitations and breathlessness in many people, but it may also be asymptomatic and therefore go undetected. Left untreated, AF is a significant risk factor for stroke: it is estimated that it is responsible for approximately 20% of all strokes and is associated with increased mortality and significant morbidity. Men are more commonly affected than women. AF prevalence increases with age and in association with heart disease, diabetes, obesity and hypertension.

AF001 – For the financial year 2024/25, this indicator is being income protected. The details of how this is applied are in section 2.1 of this document.

AF001 Rationale

- i. The register includes all patients with an initial event; paroxysmal; persistent and permanent AF.

AF001 Reporting and verification

- i. See indicator wording for requirement criteria.

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- ii. Where a patient has been diagnosed with AF and been subsequently successfully treated, if there is an 'AF resolved code' present in their record after the latest AF recording, they will be removed from the register.
 - iii. AF may resolve in some specific and limited situations. Contractors should also note that patients who have been recorded with AF resolved, continue to be at an increased risk of stroke compared to patients who have never had an episode of AF³. Contractors should consider the implications of this for individual patients before using the AF resolved code.

AF006 (NICE 2014 menu ID: NM81)

AF006 Rationale

- i. The NICE guideline on atrial fibrillation⁴ recommends that people with symptomatic or asymptomatic paroxysmal, persistent or permanent AF, atrial flutter or a continuing risk of arrhythmia recurrence after cardioversion back to sinus rhythm should have an assessment of their stroke risk using the CHA₂DS₂-VASc risk assessment tool.
- ii. The CHA₂DS₂-VASc system scores one point, up to a maximum of nine, for each of the following risk factors (except previous stroke or TIA, or age ≥75 which scores double, hence the '2'):
 - C: congestive HF (one point)
 - H: hypertension (one point)
 - A₂: age 75 or over (two points)
 - D: diabetes mellitus (one point)
 - S₂: previous stroke or TIA or thromboembolism (two points)
 - V: vascular disease (e.g. PAD, MI, aortic plaque) (one point)
 - A: age 65-74 years (one point)
 - Sc: sex category (i.e. female sex) (one point)

AF006 Reporting and verification

- i. See indicator wording for requirement criteria.

³ Adderley et al. risk of stroke and transient ischaemic attack in patients with a diagnosis of resolved atrial fibrillation: retrospective cohort studies. BMJ 2018;360:k1717
<http://dx.doi.org/10.1136/bmj.k1717>

⁴ NICE NG196 Atrial fibrillation (2021) <http://www.nice.org.uk/Guidance/NG196>

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- ii. Stroke risk assessment should be repeated on an annual basis unless the patient has previously scored 2 or more using either CHA₂DS₂-VAS_c at any time, or CHADS₂ prior to 1 April 2015.

AF008 (NICE 2022 menu ID:NM231)

AF008 Rationale

- i. This indicator aims to support people with AF who are at increased risk of stroke so that they may be offered anti-coagulation drug therapy.
- ii. The risk of stroke is five times higher for patients with AF than for the general population, and 20–30% of all strokes are attributed to this arrhythmia. The Stroke Association estimate that if AF were adequately treated, around 7,000 strokes would be prevented and over 2,000 lives saved every year in England alone.
- iii. The NHS Long Term Plan commits to reducing stroke in England in three ways:
 - diagnosing more patients with undiagnosed AF (the “detect” gap)
 - ensuring patients diagnosed with AF are offered anticoagulation where appropriate (the “protect” gap)
 - optimising the anticoagulant pathway to ensure patient outcomes are optimised (the “perfect” gap)
- iv. This indicator has been developed to support LTP ambitions on the “protect” gap and complement QOF indicator AF007, which rewards practices for ensuring that up to 70% of patients on their AF register are anticoagulated. It has two objectives:
 1. To increase the overall percentage of AF patients who are prescribed an anticoagulant
 2. To increase the use of DOACs as a proportion of anticoagulants prescribed
- v. Anticoagulation therapy can prevent around two thirds of strokes caused by AF. However, approximately 9% of patients with AF are not on any form of anticoagulant.
- vi. Likewise, 14% of patients currently receiving anticoagulation therapy are prescribed Warfarin. NICE guidance was updated in 2021 (NG196) to recommend that clinicians prescribe DOACs, rather than Warfarin as first-line

treatment for patients with AF. Warfarin is associated with a more significant risk of serious bleeding (particularly intracranial haemorrhage) than DOACs. DOACs also do not require as much monitoring, freeing up capacity in primary care and improving quality of life for patients. Other benefits of DOACs over Warfarin include:

- fixed dosing with predictable pharmacokinetics and pharmacodynamics
- low drug–drug and food interactions, and no dietary restrictions
- rapid onset and offset and shorter half-life.
- predictable effects on clotting, so routine monitoring of clotting factors is not needed.
- wide therapeutic window

- vii. In line with NG196, practices may achieve against this indicator by working to switch patients who are currently prescribed Warfarin or by prescribing patients who are newly diagnosed with AF a DOAC. However, it is important that switching patients who are currently prescribed Warfarin is done in a clinically appropriate way and as the result of a shared decision-making conversation. Recognising the importance of this, the indicator has been designed to accommodate patients who are unsuitable for a switch to DOACs or who declined to do so after a conversation with their clinician. Practices will not be penalised for continuing to prescribe Warfarin where a patient has declined a DOAC or where a DOAC is clinically unsuitable. In these circumstances, the prescription of Warfarin will count as a “success”. Please consult above and business rules for more information.

AF008 Reporting and verification

- i. See indicator wording for requirement criteria.

3.2 Secondary prevention of coronary heart disease (CHD)

Indicator	Points	Thresholds
Records		
CHD001. The contractor establishes and maintains a register of patients with coronary heart disease	4	N/A
Ongoing management		
CHD005. The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken	7	56–96%
CHD015. The percentage of patients aged 79 years or under, with coronary heart disease, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less, (or equivalent home blood pressure reading)	12	40-77%
CHD016. The percentage of patients aged 80 years or over, with coronary heart disease, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less, (or equivalent home blood pressure reading)	5	46-86%

CHD – rationale for inclusion of indicator set

- i. CHD is the single most common cause of premature death in the UK⁵. The research evidence relating to the management of CHD is well established and **if these indicators are** properly implemented can reduce the risk of death from CHD and improve the quality of life for patients. This indicator set focuses on the management of patients with established CHD.

⁵ [bhf-cvd-statistics-uk-factsheet.pdf \(ims.gov.uk\)](https://www.ims.gov.uk/bhf-cvd-statistics-uk-factsheet.pdf)

CHD001– For the financial year 2024/25, this indicator is being income protected. The details of how this is applied are in section 2.1 of this document.

CHD001 Rationale

- i. The register includes all patients who have had coronary artery revascularisation procedures, such as coronary artery bypass grafting (CABG). Patients with Cardiac Syndrome X are not included on the CHD register.
- ii. Contractors should record those with a history of myocardial infarction (MI) as well as those with a history of CHD.

CHD001 Reporting and verification

- i. See indicator wording for requirement criteria.

CHD005 (NICE 2015 menu ID: NM88)

CHD005 Rationale

- i. NICE guidance⁶ recommends all people who have had an MI should be offered aspirin (or clopidogrel if aspirin is contraindicated). Antiplatelet therapy with clopidogrel is equivalent to aspirin in preventing further cardiovascular events in people with coronary heart disease or ischaemic stroke.

CHD005 Reporting and verification

- i. See indicator wording for requirement criteria.

CHD015 (NICE 2022 menu ID: NM225)

CHD015 Rationale

- i. This indicator measures the intermediate outcome of a blood pressure of 140/90 mmHg or less in people aged 79 years or under with CHD. The aim is

⁶ NICE NG185 Acute coronary syndromes (2020) <http://guidance.nice.org.uk/NG185>

to promote secondary prevention of cardiovascular disease through satisfactory blood pressure control. This may be achieved through lifestyle advice or drug therapy.

- ii. This indicator has been updated for 2024/25 to align with updated NICE guidance which recommends differential blood pressure control targets for readings taken with Home Blood Pressure Monitoring (HBPM) and readings taken in a clinical setting. A target for stage 1 hypertension of 140/90mmHg taken in a clinic corresponds to an HBPM target of 135/85 mmHg.

CHD015 Reporting and verification

- i. See indicator wording for requirement criteria.

CHD016 (NICE 2022 menu ID: NM226)

CHD016 Rationale

- i. This indicator measures the intermediate outcome of a blood pressure of 150/90 mmHg or less in people aged 80 years and over with coronary heart disease, as recommended by the NICE clinical guideline for hypertension.⁷
- ii. This indicator has been updated for 2024/25 to align with updated NICE guidance which recommends differential blood pressure control targets for readings taken with Home Blood Pressure Monitoring (HBPM) and readings taken in a clinical setting. A target of 150/90mmHg taken in a clinic corresponds to an HBPM target of 145/85 mmHg.

CHD0016 Reporting and verification

- i. See indicator wording for requirement criteria.

⁷ NICE NG136 (2019, updated 2023) Hypertension in adults. <http://www.nice.org.uk/guidance/ng136>

3.3 Cholesterol control and lipid management (CHOL)

Indicator	Points	Thresholds
Ongoing management		
CHOL003 . Percentage of patients on the QOF Coronary Heart Disease, Peripheral Arterial Disease, Stroke/TIA or Chronic Kidney Disease Register who are currently prescribed a statin, or where a statin is declined or clinically unsuitable, another lipid-lowering therapy	14	70-95%

CHOL004. Percentage of patients on the QOF Coronary Heart Disease (CHD), Peripheral Arterial Disease (PAD), or Stroke/ Transient Ischaemic Attack (TIA) Register, who have a recording of LDL (Low-density Lipoprotein) cholesterol in the preceding 12 months that is 2.0 mmol/L or lower or where LDL cholesterol is not recorded a recording of non-HDL (High-density Lipoprotein) cholesterol in the preceding 12 months that is 2.6 mmol/L or lower	16	20-35%
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CHOL – rationale for inclusion of indicator set

- i. High cholesterol is one of the most significant risk factors for CVD. Globally, a third of ischaemic heart disease is attributable to high cholesterol. It is estimated to account for 7.1% of deaths and 3.7% of disability-adjusted life years (DALYS) in England.

CHOL003 (Based on NICE 2022 menu ID: NM212)

CHOL003 Rationale

- i. The aim of this indicator is to ensure that all patients with established cardiovascular disease, defined as Coronary Heart Disease, Peripheral Arterial Disease, Stroke/TIA or Chronic Kidney Disease receive treatment to reduce cholesterol in line with NICE guidelines, summarised here: <https://www.england.nhs.uk/aac/publication/summary-of-national-guidance-for-lipid-management/>
- ii. Treatment with a statin is recommended as first line therapy for the secondary prevention of CVD⁸. Options recommended by NICE when a statin is declined or clinically unsuitable due to contraindications or intolerance include:
 - a) Ezetimibe⁹, with the addition of bempedoic acid¹⁰ if a sufficient fall in cholesterol is not achieved with ezetimibe monotherapy.

⁸ NICE NG238 (2023) Cardiovascular disease: risk assessment and reduction, including lipid modification. <https://www.nice.org.uk/guidance/ng238>

⁹ NICE TA 385 (2022) Ezetimibe for treating primary heterozygous-familial and non-familial hypercholesterolaemia. <https://www.nice.org.uk/guidance/ta385>

¹⁰ NICE TA694 (2021) Bempedoic acid with ezetimibe for treating primary hypercholesterolaemia or mixed dyslipidaemia. <https://www.nice.org.uk/guidance/ta694>

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- b) PCSK9 inhibitors¹¹¹² for people with an LDL persistently above 3.5 or 4.0 mmol/L depending on their CVD risk profile.
 - c) Inclisiran¹³ for people with an LDL persistently 2.6mmol/L or above.
- iii. Where a statin is declined or clinically unsuitable due to contraindications or intolerance, these treatments will be included as a 'success'.

CHOL003 Reporting and verification

- i. See indicator wording for requirement criteria.

CHOL004 (NICE 2023 menu ID: NM252)

CHOL004 Rationale

- i. The purpose of the indicator is to introduce an interim outcome measure for the use of lipid lowering treatments outlined in CHOL001, for patients with established cardiovascular disease. This aims to ensure that all patients with established cardiovascular disease, defined as Coronary Heart Disease, Peripheral Arterial Disease, or Stroke/TIA are considered for intensification of therapy where there is an insufficient reduction in cholesterol with first line therapy, usually a statin.
- ii. The aim of managing LDL cholesterol to 2.0 mmol/L or lower or non-HDL cholesterol to 2.6 mmol/L or lower is aligned with the NICE guideline NG238 for Cardiovascular disease: risk assessment and reduction, including lipid modification. The full guideline can be found here: [Recommendations | Cardiovascular disease: risk assessment and reduction, including lipid modification | Guidance | NICE](#)
- iii. Where there is an insufficient reduction in cholesterol, treatment should be intensified in line with NICE guidance which is summarised here:

¹¹ NICE TA393 (2016) Alirocumab for treating primary hypercholesterolaemia and mixed dyslipidaemia. <https://www.nice.org.uk/guidance/ta393>

¹² NICE TA394 (2016) Evolocumab for treating primary hypercholesterolaemia and mixed dyslipidaemia. <https://www.nice.org.uk/guidance/ta394>

¹³ NICE TA733 (2021) Inclisiran for treating primary hypercholesterolaemia or mixed dyslipidaemia. <https://www.nice.org.uk/guidance/ta733>

<https://www.england.nhs.uk/aac/publication/summary-of-national-guidance-for-lipid-management/>.

- iv. Patients may be considered for the addition of ezetimibe or injectable therapies in line with the NICE inclusion criteria for the individual agents – for example, for inclisiran, patients must have an LDL \geq 2.6mmol/L and for the use of PCSK9i(mabs), an LDL cholesterol $>$ 3.5 or 4mmol/L depending on their risk profile. Where statin intolerance exists and ezetimibe monotherapy is ineffective, the addition of bempedoic acid may be considered in line with the statin intolerance pathway: <https://www.england.nhs.uk/aac/publication/statin-intolerance-pathway/>

CHOL004 Reporting and verification

- i. See indicator wording for requirement criteria.

3.4 Heart failure (HF)

Indicator	Points	Thresholds
Records		
HF001. The contractor establishes and maintains a register of patients with heart failure	4	N/A
Initial diagnosis		
HF008. The percentage of patients with a diagnosis of heart failure on or after 1 April 2023 which: <ol style="list-style-type: none"> Has been confirmed by an echocardiogram or by specialist assessment in the 6 months before entering on to the register; or If registered at the practice after diagnosis, with no record of the diagnosis originally being confirmed either by echocardiogram or by specialist assessment, a record of an echocardiogram or a specialist assessment within 6 months of the date of registration. 	6	50–90%
Ongoing management		

HF003. In those patients with a diagnosis of heart failure due to left ventricular systolic dysfunction or whose heart failure is due to reduced ejection fraction the percentage of patients who are currently treated with an angiotensin-converting enzyme inhibitor (ACE-I) or Angiotensin II receptor blockers (ARB)	6	60–92%
HF006. The percentage of patients with a diagnosis of heart failure due to left ventricular systolic dysfunction or whose heart failure is due to reduced ejection fraction, who are currently treated with a beta-blocker licensed for heart failure	6	60-92%
HF007. The percentage of patients with a diagnosis of heart failure on the register, who have had a review in the preceding 12 months, including an assessment of functional capacity and a review of medication to ensure medicines optimisation at maximal tolerated doses	7	50-90%

HF – rationale for inclusion of indicator set

- i. HF represents the only major cardiovascular disease with increasing prevalence and carries a poor prognosis for patients. This indicator set refers to all patients with HF unless specified otherwise.

HF001 – For the financial year 2024/25, this indicator is being income protected. The details of how this is applied are in section 2.1 of this document.

HF001 Rationale

- i. All patients with a diagnosis of HF, are included on the register.

HF001 Reporting and verification

- i. See indicator wording for requirement criteria.
- ii. There are two disease registers used for the HF indicators for the purpose of calculating APDF (practice prevalence):

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- Register 1: patients with HF is used to calculate APDF for HF001, HF008, and HF007.
 - Register 2: patients with HF due to left ventricular systolic dysfunction (LVSD) is used to calculate APDF for HF003 and HF006.
- iii. Register 1 is defined in indicator HF001. Register 2 is a sub-set of register 1 and is composed of patients with a diagnostic code for LVSD or a reduced ejection fraction of <40% as well as for HF.

HF008 (based on NM171)

HF008 Rationale

- i. The aim of this indicator is to encourage practices to confirm diagnoses of heart failure and establish the underlying causes.
- ii. Symptoms and signs suggestive of heart failure are not sufficient to make a definitive diagnosis and further investigation is required to confirm cardiac dysfunction and to identify causes. The NICE guideline for chronic heart failure¹⁴ recommends that the results of NT-proBNP tests should be used to determine whether people with suspected heart failure should be referred onwards. People with raised NT-proBNP should have echocardiography and specialist assessment within 6 weeks, but for those with very high levels this should be done more urgently, within 2 weeks. The NICE guideline for acute heart failure¹⁵ recommends that people with new suspected acute heart failure who have raised natriuretic peptides should have echocardiography within 48 hours of admission to hospital.

HF008 Reporting and verification

- i. See indicator wording for requirement criteria. For measurement purposes, three months before the date of diagnosis is defined as 93 days.

HF003 (NICE 2019 menu ID: NM172)

HF003 Rationale

¹⁴ NICE NG106 (2018) Chronic heart failure in adults. <https://www.nice.org.uk/guidance/ng106>

¹⁵ NICE CG187 (2014, updated 2021) Acute heart failure. <https://www.nice.org.uk/guidance/cg187>

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- i. There is strong clinical and cost-effectiveness evidence to support the use of ACE-I in all patients with HF with LVSD. ACE-I improve symptoms, reduce the hospitalisation rate and improve the survival rate. This is applicable in all age groups.
 - ii. It is possible to have a diagnosis of LVSD without HF, for example, asymptomatic people who might be identified coincidentally but who are at high risk of developing subsequent HF. In such cases, ACE-I's delay the onset of symptomatic HF, reduce cardiovascular events and improve long-term survival. This indicator only applies to patients with HF and therefore excludes this other group of patients who are nevertheless to be considered for treatment with ACE-I.
 - iii. NICE NG106 recommends ACE-I is used as first-line therapy in all patients with HF with reduced ejection fraction usually defined as LVSD and that ARBs are used only in patients who are intolerant of ACE-I.
 - iv. Therapies should be titrated upwards until the target or maximum tolerated dose is reached.

HF003 Reporting and verification

- i. See indicator wording for requirement criteria.

HF006 (NICE 2019 menu ID: NM173)

HF006 Rationale

- i. The NICE guideline for chronic heart failure¹⁶ recommends that beta-blockers licensed for HF are used as first-line therapy in all patients with HF with reduced ejection fraction usually defined as LVSD. It also recommends that treatment with beta-blockers is not withheld solely because of age or the presence of peripheral vascular disease (PVD), erectile dysfunction (ED), DM, interstitial pulmonary disease and COPD without reversibility. The only co-morbidities with a clear contra-indication to beta-blocker use are those with asthma and reversible airways obstruction (these groups were excluded from clinical trials).
- ii. The British National Formulary (BNF) states that “the beta-blockers bisoprolol and carvedilol are of value in any grade of stable HF and LVSD; nebivolol is licensed for stable mild to moderate HF in patients aged over 70, beta-blocker

¹⁶ NICE NG106 (2018) Chronic heart failure. <https://www.nice.org.uk/guidance/ng106>

treatment should be initiated at a very low dose and titrated very slowly over a period of weeks or months by those experienced in the management of HF. Symptoms may deteriorate initially, calling for adjustment of concomitant therapy”¹⁷.

- iii. Contractors are advised that patients already prescribed an unlicensed beta-blocker prior to diagnosis of HF due to LVSD do not have their drug therapy changed to meet the criteria of this indicator. Those patients already prescribed an unlicensed beta-blocker will be excluded from the indicator denominator.
- iv. Therapies should be titrated upwards until the target or maximum tolerated dose is reached.

HF006 Reporting and verification

- i. See indicator wording for requirement criteria.
- ii. Patients prescribed a beta-blocker unlicensed for heart failure before being given a diagnosis of heart failure will be excluded from this indicator.

HF007 (based on NM174)

HF007 Rationale

- i. Regular review is associated with improvement in quality of life and a reduction in the need for urgent hospitalisation. NICE guideline NG106 recommends short monitoring intervals (days to 2 weeks) if the clinical condition or medication has changed and 6-monthly for people with stable heart failure.
- ii. More detailed monitoring will be needed if the person has significant comorbidity or if their condition has deteriorated since the previous review, with consideration for individualised care for frailty and palliative and end of life care.

HF007 Reporting and verification

- i. See indicator wording for requirement criteria.

¹⁷ BNF. <http://www.evidence.nhs.uk/formulary/bnf/current>

3.5 Hypertension (HYP)

Indicator	Points	Thresholds
Records		
HYP001. The contractor establishes and maintains a register of patients with established hypertension	6	N/A
Ongoing management		
HYP008. The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (or equivalent home blood pressure reading)	14	40-77%
HYP009. The percentage of patients aged 80 years or over with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less (or equivalent home blood pressure reading)	5	40-80%

HYP001 – – For the financial year 2024/25, this indicator is being income protected. The details of how this is applied are in section 2.1 of this document.

HYP001 Rationale

- i. Effective treatment of hypertension aims to reduce the risk of cardiovascular problems such as heart attacks and strokes.
- ii. Patients who have had one-off high blood pressure readings and women who have been hypertensive in pregnancy should not be included in the register.

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- iii. NICE NG136¹⁸ uses the following definitions:

Stage 1 hypertension

- i. Clinic blood pressure ranging from 140/90 mmHg to 159/99 mmHg and subsequent ambulatory blood pressure monitoring (ABPM) daytime average or home blood pressure monitoring (HBPM) average blood pressure ranging from 135/85 mmHg to 149/94 mmHg.

Stage 2 hypertension

- i. Clinic blood pressure of 160/100 mmHg or higher but less than 180/120 mmHg and subsequent ABPM daytime average or HBPM average blood pressure of 150/95 mmHg or higher.

Stage 3 or severe hypertension

- i. Clinic systolic blood pressure of 180 mmHg or higher or clinic diastolic blood pressure of 120 mmHg or higher.
- ii. If clinic blood pressure reading is between 140/90 mmHg and 180/120 mmHg the NICE guideline for hypertension recommends offering ABPM to confirm a diagnosis of hypertension. If ABPM is unsuitable or the person is unable to tolerate it HBPM is a suitable alternative to confirm a diagnosis of hypertension.
- iii. For patients aged 39 or under, NICE recommend that practitioners consider seeking specialist evaluation of secondary causes of hypertension.

HYP001 Reporting and verification

- i. See indicator wording for requirement criteria.
- ii. The contractor may be required by commissioners to discuss their plans for ensuring that new diagnoses are confirmed using ABPM or HBPM as appropriate.

HYP008 (NICE 2022 menu ID: NM223)

HYP008 Rationale

¹⁸ NICE NG136 (2019, updated 2023) Hypertension in adults.
<https://www.nice.org.uk/guidance/ng136>

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- i. This indicator measures the intermediate outcome of a blood pressure of 140/90 mmHg or less in people aged 79 years or under with hypertension. Its intent is to promote the primary and secondary prevention of cardiovascular disease through satisfactory blood pressure control. The intermediate outcome can be achieved through lifestyle advice or the use of drug therapy.
 - ii. This indicator has been updated for 2024/25 to align with updated NICE guidance which recommends differential blood pressure control targets for readings taken with Home Blood Pressure Monitoring (HBPM) and readings taken in a clinical setting. A target for stage 1 hypertension of 140/90mmHg taken in a clinic corresponds to an HBPM target of 135/85 mmHg.

HYP008 Reporting and verification

- i. See indicator wording for requirement criteria.

HYP009 (NICE 2022 menu ID: NM224)

HYP009 Rationale

- i. The NICE guideline for hypertension¹⁹ recommends that patients aged 80 years and over with hypertension should be treated to a target blood pressure below 150/90 mmHg. It also recommends that this group of patients should be offered the same antihypertensive drug treatment as people aged 55-80 years, taking into account any co-morbidities.
- ii. Where people have had a lower treatment target before the age of 80 years their treatment should continue and not be adjusted or down titrated. There is an important distinction between continuing long term and well tolerated treatment in people aged 80 years and older, and starting blood pressure lowering therapy at this age.
- iii. This indicator has been updated for 2024/25 to align with updated NICE guidance which recommends differential blood pressure control targets for readings taken with Home Blood Pressure Monitoring (HBPM) and readings taken in a clinical setting. A target of 150/90mmHg taken in a clinic corresponds to an HBPM target of 145/85 mmHg.

HYP009 Reporting and verification

¹⁹ NICE NG136 (2019, updated 2023) Hypertension in adults. <http://www.nice.org.uk/guidance/ng136>

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- i. See indicator wording for requirement criteria.

3.6 Peripheral arterial disease (PAD)

Indicator	Points	Thresholds
Records		
PAD001. The contractor establishes and maintains a register of patients with peripheral arterial disease	2	N/A

PAD – rationale for inclusion of indicator set

- i. PAD is one of the three main categories of CVD and patients with PAD, including those who are asymptomatic, have an increased risk of mortality from CVD due to MI and stroke. The relative risks of all-cause mortality are two to three times that of age and sex matched to groups without PAD.
- ii. Treatment of PAD focuses on cardiovascular risk factor management. Smoking is a very important risk factor for PAD and management of PAD includes smoking cessation (see smoking indicator set). Other established risk factors are high blood pressure and diabetes. This would mean that patients with PAD and high blood pressure would also be included in the hypertension indicator set and patients with diabetes and PAD would also be included in the diabetes indicator set.
- iii. Further information - NICE CG147 (2012, updated 2020). Peripheral arterial disease. <https://www.nice.org.uk/guidance/cg147>

PAD001 (NICE 2011 menu ID: NM32) – For the financial year 2024/25, this indicator is being income protected. The details of how this is applied are in section 2.1 of this document.

PAD001 Rationale

- i. Patients with PAD may have symptoms but can also be asymptomatic. About 20 per cent of patients aged 60 or over have PAD, although only a quarter of these patients have symptoms. Symptoms become severe and progressive in approximately 20 per cent of patients with symptomatic PAD.
- ii. Reduced ankle brachial pressure index is an independent predictor of cardiac and cerebrovascular morbidity and mortality and may help to identify patients who would benefit from secondary prevention.

PAD001 Reporting and verification

- i. See indicator wording for requirement criteria.

3.7 Stroke and TIA (STIA)

Indicator	Points	Thresholds
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Records		
STIA001. The contractor establishes and maintains a register of patients with stroke or TIA	2	N/A
Ongoing management		
STIA007. The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 12 months that an anti-platelet agent, or an anti-coagulant is being taken	4	57–97%
STIA014. The percentage of patients aged 79 years or under, with a history of stroke or TIA, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (or equivalent home blood pressure reading)	3	40-73%
STIA015. The percentage of patients aged 80 years or over, with a history of stroke or TIA, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less, (or equivalent home blood pressure reading)	2	46-86%

STIA – rationale for inclusion of indicator set

- i. Stroke is the third most common cause of death in the developed world. One quarter of stroke deaths occur under the age of 65. There is evidence that appropriate diagnosis and management can improve outcomes²⁰.

STIA001 – For the financial year 2024/25, this indicator is being income protected. The details of how this is applied are in section 2.1 of this document.

STIA001 Rationale

- i. For patients diagnosed prior to 1 April 2003 it is accepted that various diagnostic criteria may have been used. For this reason, the presence of the diagnosis of stroke or TIA in the record will be acceptable. Generally, patients with a diagnosis of transient global amnesia or vertebra-basilar insufficiency are not included in the retrospective register. However, contractors may wish

²⁰ NICE NG128 (2019) Stroke and transient ischaemic attack in over 16s
<http://www.nice.org.uk/guidance/ng128>

to review patients previously diagnosed and, if appropriate, attempt to confirm the diagnosis.

- ii. It is up to the contractor to decide, on clinical grounds, when to include a patient on the register (e.g. when a 'dizzy spell' becomes a TIA). Patient records coded with 'Amaurosis fugax', but without a code for TIA are excluded from the register.

STIA001 Reporting and verification

- i. See indicator wording for requirement criteria.

STIA007 (NICE 2015 menu ID: NM94)

STIA007 Rationale

- i. Long-term anti-platelet therapy reduces the risk of serious vascular events following a stroke by about a quarter. It is advised that anti-platelet therapy is prescribed for the secondary prevention of recurrent stroke and other vascular events in patients who have sustained an ischaemic cerebrovascular event.
- ii. The British National Formulary (BNF)²¹ makes the following recommendations:

“Patients should receive long-term treatment following a transient ischaemic attack or an ischaemic stroke to reduce the risk of further cardiovascular events.

Following a transient ischaemic attack or an ischaemic stroke (not associated with AF), long-term treatment with clopidogrel [unlicensed in transient ischaemic attack] is recommended. If clopidogrel is contra-indicated or not tolerated, patients can receive modified-release dipyridamole in combination with aspirin; if both aspirin and clopidogrel are contra-indicated or not tolerated, then modified-release dipyridamole alone is recommended; if both modified-release dipyridamole and clopidogrel are contra-indicated or not tolerated, then aspirin alone is recommended.

Patients with stroke associated with AF should be reviewed for long-term treatment with warfarin sodium or an alternative anti-coagulant (see initial management under ischaemic stroke).”

²¹ BNF stroke treatment summary. <https://bnf.nice.org.uk/treatment-summary/stroke.html>

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- iii. Further information - NICE TA210 (201) Clopidogrel and modified-release dipyridamole for the prevention of occlusive vascular events.
<http://www.nice.org.uk/guidance/TA210>

STIA007 Reporting and verification

- iii. See indicator wording for requirement criteria.

STIA014 (NICE 2022 menu ID: NM227)

STIA014 Rationale

- i. This indicator measures the intermediate outcome of a blood pressure of 140/90 mmHg or less in people aged 79 years and under who have experienced a stroke or TIA. It aims to promote the secondary prevention of cardiovascular disease through satisfactory blood pressure control. The intermediate outcome can be achieved through lifestyle advice or drug therapy subject to the caveat below.
- ii. The NICE guideline on hypertension²² recommends drug therapy in people aged 79 years and under with stage 1 hypertension and cardiovascular disease. Antihypertensive drug treatment is recommended for people of any age with stage 2 hypertension.
- iii. This indicator has been updated for 2024/25 to align with updated NICE guidance which recommends differential blood pressure control targets for readings taken with Home Blood Pressure Monitoring (HBPM) and readings taken in a clinical setting. A target for stage 1 hypertension of 140/90mmHg taken in a clinic corresponds to an HBPM target of 135/85 mmHg.

STIA014 Reporting and verification

- i. See indicator wording for requirement criteria.

STIA015 (NICE 2022 menu ID: NM228)

STIA015 Rationale

- i. This indicator measures the intermediate outcome of a blood pressure of 150/90 mmHg or less in people aged 80 years and over with a history of

²² NICE NG136 (2019, updated 2023) Hypertension in adults.
<http://www.nice.org.uk/guidance/ng136>

stroke or TIA. The aim of treating people to this target is to promote secondary prevention of vascular events through satisfactory blood pressure control.

- ii. This indicator has been updated for 2024/25 to align with updated NICE guidance which recommends differential blood pressure control targets for readings taken with Home Blood Pressure Monitoring (HBPM) and readings taken in a clinical setting. A target of 150/90mmHg taken in a clinic corresponds to an HBPM target of 145/85 mmHg.

STIA015 Reporting and verification

- i. See indicator wording for requirement criteria.

3.8 Diabetes mellitus (DM)

Indicator	Points	Thresholds
Records		
DM017. The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed	6	N/A
Ongoing management		
DM006. The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs)	3	57–97%

DM012. The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 12 months	4	50–90%
DM014. The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register	11	40–90%
DM033. The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (or equivalent home blood pressure reading)	10	38-78%
DM020. The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months	17	35-75%
DM021. The percentage of patients with diabetes, on the register, with moderate or severe frailty in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months	10	52-92%
DM022. The percentage of patients with diabetes aged 40 years and over, with no history of cardiovascular disease and without moderate or severe frailty, 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)	4	50-90%
DM023. The percentage of patients with diabetes and a history of cardiovascular disease (excluding haemorrhagic stroke) who are currently treated with a statin	2	50-90%

DM – rationale for inclusion of indicator set

- i. Diabetes mellitus (DM) is one of the common endocrine diseases affecting all age groups with approximately 7 million people in the England having the condition. Effective control and monitoring can reduce mortality and morbidity.

Much of the management and monitoring of diabetes, particularly type 2 diabetes, is undertaken by the GP and members of the primary care team.

ii. Further information:

- NICE NG28 (2015, updated 2022) Type 2 diabetes in adults. <http://www.nice.org.uk/guidance/NG28>
- NICE NG19 (2015, updated 2019). Diabetic foot problems. <http://www.nice.org.uk/guidance/NG19/>
- NICE NG18 (2015, updated 2023). Diabetes (type 1 and type 2) in children and young people. <http://www.nice.org.uk/guidance/NG18>
- NICE NG17 (2015, updated 2022). Type 1 diabetes in adults. <http://www.nice.org.uk/guidance/NG17>

iii. The indicators for diabetes are generally those which would be expected to be done, or checked, in an annual review. There is no requirement for the contractor to carry out all these items, but it is the contractor's responsibility to ensure that they have been done.

DM017 (NICE 2011 menu ID: NM41) – For the financial year 2024/25, this indicator is being income protected. The details of how this is applied are in section 2.1 of this document.

DM017 Rationale

- i. A greater understanding and knowledge of the complexities of diabetes has led to increasing difficulty in accurately diagnosing or classifying the type of diabetes. In March 2011, a report by the Royal College of General Practitioners (RCGP) and NHS Diabetes was published which examined the issue of coding, classification, and diagnosis of diabetes in primary care in England²³. The summary findings of the report included an algorithm to provide guidance to healthcare professionals on making a new diagnosis of diabetes. In line with this report, the diabetes register indicator includes all

²³ RCGP and NHS Diabetes. Coding, classification and diagnosis of diabetes. 2011. https://clininf.eu/wp-content/uploads/2017/02/nhs_diabetes_and_rcgp_cod_final_report.pdf

types of diabetes within the proposed algorithm. Women with gestational diabetes are excluded from this indicator set.

- ii. If it is too early in the clinical course to diagnose the specific type of diabetes, or if the specific diagnosis is uncertain, contractors are asked to use the parent term 'diabetes mellitus'. Contractors are expected to update these patients' records when their specific type of diabetes is confirmed. This is advised to be within six to 12 months of the initial diagnosis of diabetes mellitus.
- iii. This indicator does not specify how the diagnosis is made and a record of the diagnosis will, for the purposes of the QOF, be regarded as sufficient evidence of diabetes. However, there are a substantial number of patients with diabetes who remain undiagnosed and a number of patients receiving treatment with an incorrect diagnosis of diabetes. Contractors are therefore encouraged to adopt a systematic approach to the diagnosis of diabetes.
- iv. The World Health Organisation (WHO) 2006²⁴ states that fasting plasma glucose ≥ 7.0 mmol/l (126 mg/dl) or 2-h plasma glucose ≥ 11.1 mmol/l (200 mg/dl) is used as criteria for diagnosing diabetes.
- v. In 2011 an addendum to the 2006 WHO diagnostic criteria was published to allow the use of glycated haemoglobin (HbA1c) in diagnosing DM²⁵. The addendum does not invalidate the 2006 recommendations on the use of plasma glucose measurements to diagnose diabetes. The WHO recommend that HbA1c can be used as a diagnostic test for diabetes, provided that stringent quality assurance tests are in place and assays are standardised to criteria aligned to the international reference values and there are no conditions present that preclude its accurate measurement. An HbA1c of 48 mmol/mol (6.5 per cent) is recommended as the cut-off point for diagnosing diabetes. A value less than 48 mmol/mol (6.5 per cent) does not exclude diabetes diagnosed using glucose tests.
- vi. The use of HbA1c for diagnosing diabetes can avoid the problem of day-to-day variability of glucose values and importantly it avoids the need for the patient to make preceding dietary preparations (such as fasting or consuming a glucose drink).

²⁴ WHO. Definition and diagnosis of DM and intermediate hyperglycaemia. 2006.

www.who.int/diabetes/publications/Definition%20and%20diagnosis%20of%20diabetes_new.pdf

²⁵ WHO. Use of HbA1c in the diagnosis of DM. Abbreviated report of a WHO consultation. 2011. www.who.int/diabetes/publications/report-hba1c_2011.pdf

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- vii. The WHO also recommends that the diagnosis of diabetes in an asymptomatic patient is not made on the basis of a single abnormal plasma glucose or HbA1c value. At least one additional HbA1c or plasma glucose test result with a value in the diabetic range is required, either fasting, from a random (casual) sample, or from an oral glucose tolerance test (OGTT).
 - viii. The business rules include a clinical code for “diabetes in remission”. This refers to maintenance of non-diabetic glycaemic levels off all glucose-lowering medication. For type 2 diabetes, this may be achieved through lifestyle interventions or bariatric surgery. However, people with remission of diabetes may still experience the macrovascular and microvascular complications of diabetes and therefore need continued monitoring.
 - ix. Practices should review their patient records and re-code patients previously coded as “diabetes resolved” as “diabetes in remission” if they still require monitoring for the reasons outlined above.

DM017 Reporting and verification

- i. See indicator wording for requirement criteria.
- ii. Verification – Commissioners may require randomly selecting a number of patient records of patients coded with the parent term ‘diabetes mellitus’ and requesting information about how long the specific diagnosis has been unknown.
- iii. Commissioners may require contractors to demonstrate that they have processes in place to ensure that patient records are updated once a specific diagnosis has been made. Good practice is that this occurs within six to 12 months of the initial diagnosis.

DM006 (NICE 2015 menu ID: NM95)

DM006 Rationale

- i. NICE guidelines^{26, 27} recommend the use of ACE-I (or ARBs) to slow the progression of renal disease in patients with diabetes with urine albumin: creatinine ratio (ACR) ≥ 3 mg/mmol. Trial evidence suggests that these are most effective when given in the maximum dose quoted in the BNF. **NICE**

²⁶ NICE NG17 (2015, updated 2021) Type 1 diabetes in adults.

<https://www.nice.org.uk/guidance/ng17>

²⁷ NICE NG28 (2015, updated 2021). Type 2 diabetes in adults.

<https://www.nice.org.uk/guidance/ng28>

guidelines also recommend that SGLT2i should be offered or considered, depending on the level of ACR, in people with type 2 diabetes and renal disease.

- ii. It is recommended that patients with a diagnosis of micro-albuminuria or proteinuria are commenced on an ACE-I or considered for treatment with ARBs.

DM006 Reporting and verification

- i. See indicator wording for requirement criteria.

DM012 (NICE 2010 menu ID: NM13)

DM012 Rationale

- i. Patients with diabetes are at high risk of foot complications that could lead to ulcer, amputation or death. Evaluation and risk classification on an annual basis are important for the detection of feet most at risk.
- ii. The NICE guideline on diabetic foot problems²⁸ outlines foot risk classification and recommends at least annual reassessment.
- iii. For the purposes of QOF, the clinical codes for 'moderate risk' are used to record the concept of 'increased risk'.

DM012 Reporting and verification

- i. See indicator wording for requirement criteria.

DM014 (NICE 2011 menu ID: NM27)

DM014 Rationale

- i. Diabetes is a progressive long-term medical condition that is predominantly managed by the person with the diabetes and/or their carer as part of their daily life. Accordingly, understanding of diabetes, informed choice of management options and the acquisition of relevant skills for successful self-management play an important role in achieving optimal outcomes. These needs are not always fulfilled by conventional clinical consultations.

²⁸ NICE NG19 (2015, updated 2019) Diabetic foot problems: prevention and management. <http://www.nice.org.uk/guidance/NG19/>

Structured educational (SE) programmes have been designed not only to improve people's knowledge and skills, but also to help motivate and sustain people with both type 1 and type 2 diabetes in taking control of their condition and in delivering effective self-management. Structured education programmes are supported by NICE guidance^{29,30}.

- ii. The indicator requires that SE is offered to every person with diabetes and/or their carer from the time of diagnosis. An alternative education programme of equal standard may be offered to people unable or unwilling to participate in group education sessions.
- iii. There are several accredited digital education programmes including nationally commissioned services which are available to all GPs to refer in to. Healthy Living is a programme for people living with type 2 diabetes and their carers, and My Type 1 is for people living with type 1 diabetes. Referral to these programmes will also meet the criteria for this indicator. These programmes are also available to people who have been diagnosed within any timeframe, supporting annual reinforcement.
- iv. This indicator suggests referral to a programme within nine months of entry onto the diabetes register to be appropriate for people with type 1 or type 2 diabetes. A timeframe of nine months for this indicator has been set to take into account the differing expectations for referral into SE programmes from diagnosis for people with type 1 and type 2 diabetes.

DM014 Reporting and verification

- i. See indicator wording for requirement criteria. For measurement purposes, nine months is defined as 279 days.

DM033 (based on NICE 2023 menu ID: NM233)

DM033 Rationale

- i. Lowering blood pressure in people with diabetes reduces the risk of developing micro and macrovascular complications.
- ii. Applying universal BP targets to all people with diabetes may inadvertently lead to the potential for undertreatment in those with less complex need and

²⁹ NICE NG17 (2015, updated 2021) Type 1 diabetes in adults.

<https://www.nice.org.uk/guidance/ng17>

³⁰ NICE NG28 (2015, updated 2021). Type 2 diabetes in adults.

<https://www.nice.org.uk/guidance/ng28>

overtreatment in those with complex needs and co-morbidity³¹. This indicator focuses upon blood pressure management in people with diabetes without moderate or severe frailty and thus aims to reduce potential undertreatment and support better control of biomedical targets in people with the greatest capacity to benefit.

- iii. Contractors should note that the BP target in this indicator is higher than that recommended in NG17 for patients with type 1 diabetes aged 79 or under with ACR of 70 mg/mmol or more, where they should be aiming for under 130/80mmHg. Contractors should use their clinical judgement when setting individual blood pressure targets, particularly for people with advanced age, living with frailty or multimorbidity.
- iv. This indicator has been updated for 2024/25 to align with updated NICE guidance which recommends differential blood pressure control targets for readings taken with Home Blood Pressure Monitoring (HBPM) and readings taken in a clinical setting. A target for stage 1 hypertension of 140/90mmHg taken in a clinic corresponds to an HBPM target of 135/85 mmHg.

DM033 Reporting and verification

- i. See indicator wording for requirement criteria.

DM020 (NICE 2018 menu ID: NM157)

DM020 Rationale

- i. Glycated haemoglobin (HbA1c) is commonly used to monitor glucose control as it provides a measure of average glycaemia over the preceding 8-12 weeks. Rising levels of HbA1c increase the risk of mortality and developing macrovascular and microvascular complications. However, applying universal target levels regardless of comorbidities may inadvertently lead to over-treatment, especially in older people with type 2 diabetes and people living with frailty.³² This indicator allows for an individualised management approach that adjusts care according to an individual's frailty status. It aims to enable patients without moderate or severe frailty to benefit from tighter glycaemic control. Whilst the target in this indicator is higher than those presented in

³¹ Kearney et al. Overtreatment and undertreatment: time to challenge our thinking. BJGP. 2019;67(633):442-443.

³² Strain et al. Type 2 diabetes mellitus in older people: a brief statement of key principles of modern day management including the assessment of frailty. Diabetic medicine. 2018;35(7): 838-845.

NICE guidelines^{33, 34}, this has been pragmatically selected as it represents the point at which people with type 2 diabetes should be considered for treatment intensification.

DM020 Reporting and verification

- i. See indicator wording for requirement criteria.

DM021 (NICE 2018 menu ID: NM158)

DM021 Rationale

- i. This indicator allows for an individualised management approach that adjusts care according to an individual's frailty status. It aims to reduce complications and improve quality of life for people with moderate or severe frailty. NICE guidelines recommend that individualised HbA1c targets should be agreed with people with both type 1 and type 2 diabetes which consider factors such as their daily activities, aspirations, likelihood of complications, comorbidities, and occupation. Individual targets, even for people with moderate or severe frailty, should be lower than the level specified in this indicator. The target in this indicator has been pragmatically selected as a level that HbA1c should not go beyond to avoid people becoming symptomatic of hyperglycaemia.

DM021 Reporting and verification

- i. See indicator wording for requirement criteria.

DM022 (NICE 2018 menu ID: NM162)

DM022 Rationale

- i. Cardiovascular risk is elevated in people with type 1 and type 2 diabetes. The NICE guideline for cardiovascular disease risk assessment and lipid modification³⁵ recommends that people with type 1 diabetes are offered statin treatment for primary prevention when they are older than 40 years, or they

³³ NICE NG17 (2015, updated 2021) Type 1 diabetes in adults.

<http://www.nice.org.uk/guidance/NG17>

³⁴ NICE NG28 (2015, updated 2021) Type 2 diabetes in adults. www.nice.org.uk/guidance/NG28

³⁵ NICE NG238 (2023) Cardiovascular disease: risk assessment and reduction, including lipid modification. <https://www.nice.org.uk/guidance/ng238>

have had diabetes for more than 10 years, or they have established nephropathy or other CVD risk factors. It also recommends that people with type 2 diabetes should be offered statin therapy if they have a 10% or greater 10-year risk of developing CVD, estimated using the QRISK3 assessment tool. The business rules for this indicator include clinical codes for QRISK, QRISK2, QRISK3, Framingham and Joint British Societies risk score.

- ii. In 2023, the NICE guideline for cardiovascular disease: risk assessment and reduction, including lipid modification reinforced the recommendation of high-intensity statin treatment, for primary prevention (atorvastatin 20mg) and secondary prevention (atorvastatin 80mg).

DM022 Reporting and verification

- i. See indicator wording for requirement criteria.
- ii. People with type 2 diabetes who have a less than 10% 10-year risk of developing CVD recorded in the preceding 3 years will be excluded from the denominator for this indicator.

DM023 (NICE 2018 menu ID: NM163)

DM023 Rationale

- i. The NICE guideline for cardiovascular disease risk assessment and lipid modification³⁶ recommends that lipid lowering treatments should be offered for the secondary prevention of CVD. For most people, this will include high intensity statin therapy, which has been shown to lower levels of low-density lipoprotein (LDL) cholesterol and is associated with a reduction in MI, coronary heart disease and stroke. Treatment should start with atorvastatin 80mg, however there are situations in which a lower dose or alternative lipid lowering therapy should be used. This indicator promotes the prescribing of an appropriate statin.
- ii. **DM023 Reporting and verification**

³⁶ NICE NG238 (2023) Cardiovascular disease: risk assessment and reduction, including lipid modification. <https://www.nice.org.uk/guidance/ng238>

- i. See indicator wording for requirement criteria.

3.9 Asthma (AST)

Indicator	Points	Thresholds
Records		
AST005. The contractor establishes and maintains a register of patients with asthma aged 6 years or over, excluding patients with asthma who have been prescribed no asthma related drugs in the preceding 12 months	4	N/A
Initial diagnosis		
<p>AST011. The percentage of patients with a diagnosis of asthma on or after 1 April 2023 with either:</p> <ol style="list-style-type: none"> 1. A record of quality assured spirometry and one other objective test (FeNO or, bronchodilator reversibility or peak flow variability) between 3 months before or 6 months after diagnosis; or 2. If newly registered in the preceding 12 months with a diagnosis of asthma recorded on or after 1 April 2023 but no record of objective tests being performed at the date of the registration, with a quality assured spirometry and one other objective test (FeNO or bronchodilator reversibility or peak flow variability) recorded within 6 months of the registration. 	15	45–80%
Ongoing management		

AST007. The percentage of patients with asthma on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using a validated asthma control questionnaire, a recording of the number of exacerbations, an assessment of inhaler technique and a written personalised action plan	20	45–70%
AST008. The percentage of patients with asthma on the register aged 19 or under, in whom there is a record of either personal smoking status or exposure to second-hand smoke in the preceding 12 months	6	45–80%

AST – rationale for inclusion of indicator set

- i. Asthma is a common condition which responds well to appropriate management and is principally managed in primary care.

AST005 (based on NM165) – For the financial year 2024/25, this indicator is being income protected. The details of how this is applied are in section 2.1 of this document.

AST005 Rationale

- i. The diagnosis of asthma is a clinical one; there is no single confirmatory diagnostic blood test, radiological investigation or histopathological investigation. In most patients, the diagnosis can be corroborated by suggestive changes in lung function tests and measurement of airways inflammation.
- ii. One of the main difficulties in asthma is the variable and intermittent nature of asthma. Some of the symptoms of asthma are shared with diseases of other systems. Features of an airway disorder in adults such as cough, wheeze and breathlessness should be corroborated where possible by measurement of airflow inflammation, limitation and reversibility. Obstructive airways disease produces a decrease in peak expiratory flow (PEF) and forced expiratory volume in one second (FEV1) but which may resolve after bronchodilators have been administered. One or both of these should be measured, but may be normal if the measurement is made between episodes of bronchospasm.

Asthmatic inflammation of the airways produces higher levels of the fraction of exhaled nitric oxide (FeNO), which can be measured using a point of care test. If lung function and FeNO are repeatedly normal in the presence of symptoms, then the diagnosis of asthma is in doubt.

Children

- i. A definitive diagnosis of asthma can be difficult to obtain in young children. Asthma is to be suspected in any child with wheezing, ideally heard by a health professional on auscultation and distinguished from upper airway noises.
- ii. In school children, bronchodilator responsiveness, PEF variability tests of airways inflammation or bronchial hyperactivity may be used to confirm the diagnosis, with the same reservations as above.
- iii. Focus the initial assessment in children suspected of having asthma on the:
 - presence of key features in the history and examination
 - careful consideration of alternative diagnoses
- iv. It is well recognised that asthma is a variable condition and many patients will have periods when they have minimal symptoms. It is inappropriate to attempt to monitor symptom-free patients on no therapy or very occasional therapy.
- v. This produces a significant challenge for QOF. It is important that resources in primary care are targeted to patients with the greatest need – in this instance, patients who will benefit from asthma review rather than insistence that all patients with a diagnostic label of asthma are reviewed on a regular basis.
- vi. It is for this reason that the asthma register is constructed annually by searching for patients with a history of asthma, excluding those who have had no prescription for asthma-related drugs in the preceding 12 months.
- vii. Further information - SIGN guideline 158³⁷. NICE guideline NG80: Asthma: diagnosis, monitoring and chronic asthma management³⁸.

AST005 Reporting and verification

- i. See indicator wording for requirement criteria.
- ii. Part of the register criteria for asthma is based on appropriate prescribing of therapies. From October 2014, the business rules were updated to exclude

³⁷ <https://www.sign.ac.uk/our-guidelines/british-guideline-on-the-management-of-asthma/>

³⁸ NICE NG80 (2017, updated 2021) Asthma. <https://www.nice.org.uk/Guidance/NG80>

drug therapies licensed only for use in patients with a diagnosis of COPD as they are not licensed as a treatment for asthma.

- iii. Patients with asthma whose sole asthma medication is one associated with COPD will no longer appear on the QOF asthma register. Patients receiving additional, appropriate asthma treatment such as short-acting bronchodilators or steroid inhalers will remain on the register. Practices may wish to review the records of any patients affected by this change to review their asthma treatment however, a change in prescribing should only be done where clinically appropriate.

AST011 (based on NM166)

AST011 Rationale

- i. This indicator was updated from AST006 in 2023/24 to allow re-baselining of the start date to reflect changed requirements and the difficulty undertaking spirometry during the COVID-19 pandemic.
- ii. The aim of this indicator is to encourage use of objective tests to confirm asthma diagnosis, and subsequently improve accuracy of diagnosis and reduce incidences of patients receiving inappropriate care. This will mean that some patients may require referral for the necessary diagnostic tests to be completed following locally commissioned pathways. Results of testing should inform subsequent treatment for people with asthma and lead to improved health and wellbeing.
- iii. Spirometry is the key investigation for distinguishing obstructive and restrictive respiratory conditions and will determine subsequent investigations. It is crucial that diagnostic spirometry is performed to published quality standards^{39,40} and therefore referral to a specialist service may be required.
- iv. Adults (aged 17 and over) should be diagnosed, if they have symptoms suggestive of asthma and:

³⁹ Levy ML, Quanjer PH, Booker R, Cooper BG, Holmes S, Small I. Diagnostic spirometry in primary care: Proposed standards for general practice compliant with ATS and Euro Respiratory Society recommendations: a General Practice Airways Group document in association with the Association for Respiratory Technology & Physiology and Education for Health. PCRJ. 2009; 18:130-47. <http://dx.doi.org/10.4104/pcrj.2009.00054>

⁴⁰ Association for respiratory technology and physiology. A guide to performing quality assured diagnostic spirometry. <http://www.artp.org.uk/>

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- a FeNO level of 40 parts per billion (ppb) or more with either positive bronchodilator reversibility or positive peak flow variability or bronchial hyperreactivity, or
 - a FeNO level between 25 and 39 ppb and a positive bronchial challenge test, or
 - positive bronchodilator reversibility and positive peak flow variability irrespective of FeNO level⁴¹
- v. Children (aged 5 to 16) should be diagnosed if they have symptoms suggestive of asthma and:
- a FeNO level of 35 ppb or more and a positive peak flow variability, or
 - obstructive spirometry and positive bronchodilator reversibility⁴²
- vi. Referral may be required for FeNO testing and for challenge testing to measure bronchial hyperreactivity, which is a hallmark of asthma. The bronchial challenge test involves breathing in gradually increasing doses of a medication, such as methacholine or mannitol, whilst measuring the FEV1.
- vii. If an adult, young person or child with symptoms suggestive of asthma cannot perform a particular test, try to perform at least 2 other objective tests. Diagnose suspected asthma based on symptoms and any positive objective test results. PCAs are available where people cannot perform objective testing.
- viii. It is recognised that the current structure of diagnostic services in primary care means delivery of objective testing in children and adults with equity of access is a significant challenge. A PCA is available allowing anyone who does not have access to objective testing to support their asthma diagnosis to be removed from the denominator. Ensuring availability of quality assured spirometry and FeNO measurement to support an accurate diagnosis in all adults and children aged 5 years and over remains a clinical priority and this will allow time for local areas to set up services and appropriately train staff.

⁴¹ NICE NG80 (2017, updated 2021) Asthma. <https://www.nice.org.uk/Guidance/NG80>

⁴² NICE NG80 (2017, updated 2021) Asthma. <https://www.nice.org.uk/Guidance/NG80>

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- ix. NHS England is supporting systems to make objective testing, and spirometry in particular, available in the community. Where objective testing is not available, clinical guidance should be followed⁴³⁴⁴.
 - x. More specialist assessment may be required in those in whom the diagnosis is still unclear, which may include assessment of airway inflammation (e.g. nitric oxide measurement), bronchial hyper-responsiveness testing and consideration of alternative diagnoses. It is recommended that children with combined food allergy and asthma and any patient with late onset asthma where there is a suspicion of an occupational cause are referred for specialist assessment.

If another diagnosis is more likely

- i. If an alternative diagnosis is suspected, investigation and management are to follow guidelines for that condition.

Co-morbidity: asthma and COPD

- i. A proportion of patients with asthma will have both asthma and COPD e.g. they have airway obstruction that does not reverse to normal but also have substantial reversibility⁴⁵.

AST011 Reporting and verification

See indicator wording for requirement criteria. For measurement purposes, three months prior to diagnosis is defined as 93 days.

AST007 (based on NM167)

AST007 Rationale

- i. This indicator aims to encourage the provision of good quality annual asthma reviews. When done well, these reviews can help identify people at increased

⁴³ NICE NG80 ((2017, updated 2021) Asthma. Sections 1.3 and 1.4 (specifically pages 10 and 11 and algorithms B and C for objective test) <https://www.nice.org.uk/Guidance/NG80>)

⁴⁴ BTS/SIGN clinical guideline 158. Management of asthma. 2019 (specifically pages 26 and 27 and diagnostic algorithm). <https://www.sign.ac.uk/our-guidelines/british-guideline-on-the-management-of-asthma/>

⁴⁵ NICE NG115 (2018, updated 2019) Chronic obstructive pulmonary disease in over 16s. <https://www.nice.org.uk/guidance/NG115>

risk of poor outcomes and allow them to use information from their review to self-manage their asthma and maximise their future health.

- ii. QOF encourages the different components of a good quality asthma care as recommended by NICE in NG80. The indicator explicitly requires an assessment of asthma control using a validated asthma control questionnaire using the [Asthma Control Questionnaire](#) or [Asthma Control Test](#), a recording of the number of exacerbations, a face-to-face assessment of inhaler technique (or by video where that's not possible) and a written personalised action plan.
- iii. If the asthma appears to be uncontrolled, clinicians should take into account the possible reasons below before adjusting medicines:
 - alternative diagnoses
 - smoking (active or passive)
 - poor inhaler technique
 - lack of adherence
 - occupation exposures
 - psychosocial factors
 - seasonal or environmental factors
- iv. The BTS/SIGN clinical guideline⁴⁶ proposes a structured system for recording inhaler technique, morbidity, PEF levels, current treatment and asthma action plans.
- v. There are a range of resources available, supported and / or hosted by organisations like the Primary Care Respiratory Society (PCRS) and the Association of Respiratory Nurse Specialists, to help. These include a visual guide on how to optimise asthma reviews, produced by Greener Practice⁴⁷, a guide produced by PCRS on the basics of a good asthma review, along with videos to support clinicians in discussion with patients⁴⁸. Asthma and Lung UK also has information for healthcare professionals, including advice on developing action plans, helping patients use their inhaler and patient resources⁴⁹.

⁴⁶ BTS/SIGN clinical guideline 158. Management of asthma. 2019. <https://www.sign.ac.uk/our-guidelines/british-guideline-on-the-management-of-asthma/>

⁴⁷ <https://www.greenerpractice.co.uk/high-quality-and-low-carbon-asthma-care/resources/>

⁴⁸ <https://www.pcrs-uk.org/resource/good-building-blocks-asthma-review>

⁴⁹ <https://www.asthmaandlung.org.uk/research-health-professionals/health-professionals>

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- vi. For more information on asthma management and recommendations made to prevent deaths from asthma in the future, see the National Review of Asthma Deaths (NRAD) ⁵⁰.

AST007 Reporting and verification

- i. See indicator wording for requirement criteria.
- ii. The business rules require that contractors code the review and the assessment of asthma control using a validated asthma control questionnaire in the month before the asthma review, the number of exacerbations in the month before the asthma review and the provision of a written personalised asthma plan recorded on the same day as the asthma review in order to meet the requirements of this indicator.

AST008 (based on NM168) – For the financial year 2024/25, this indicator is being income protected. The details of how this is applied are in section 2.1 of this document.

AST008 Rationale

- i. There are very few studies that have considered the question of whether smoking affects asthma severity⁵¹. One controlled cohort study suggested that exposure to passive smoke at home delayed the recovery from an acute attack. There is also epidemiological evidence that smoking is associated with poor asthma control⁵². NICE guidance recommends taking smoking status (active or passive) into account before starting or adjusting medicines for asthma⁵³.
- ii. This indicator aims to encourage general practice to ask children and young people aged 6 to 19 years with asthma about their exposure to tobacco and second-hand smoke. Support can then be offered to patients and the people they live with to understand the risks of smoking and exposure to second-hand smoke for those with asthma, and how to access smoking cessation services.

AST008 Reporting and verification

⁵⁰ <https://www.rcplondon.ac.uk/projects/national-review-asthma-deaths>

⁵¹ <https://erj.ersjournals.com/content/41/3/716>

⁵² Price et al. ClinExp Allergy 2005; 35: 282-287

⁵³ NICE NG80 (2017, updated 2021) Asthma. <https://www.nice.org.uk/Guidance/NG80>

i. See indicator wording for requirement criteria.

3.10 Chronic obstructive pulmonary disease (COPD)

Indicator	Points	Thresholds
Records		
COPD015. The contractor establishes and maintains a register of: <ol style="list-style-type: none"> 1. Patients with a clinical diagnosis of COPD before 1 April 2023; and 2. Patients with a clinical diagnosis of COPD on or after 1 April 2023 whose diagnosis has been confirmed by a quality assured post-bronchodilator spirometry FEV1/FVC ratio below 0.7 between 3 months before or 6 months after diagnosis (or if newly registered at the practice in the preceding 12 months without a record of spirometry having been performed, a record of an FEV1/FVC ratio below 0.7 recorded within 6 months of registration); and 3. Patients with a clinical diagnosis of COPD on or after 1 April 2023 who are unable to undertake spirometry. 	8	N/A
Ongoing management		
COPD010. The percentage of patients with COPD on the register, who have had a review in the preceding 12 months, including a record of the number of exacerbations and an assessment of breathlessness using the Medical Research Council dyspnoea scale	9	50–90%
COPD014. The percentage of patients with COPD and Medical Research Council (MRC) dyspnoea scale ≥ 3 at any time in the preceding 12 months, with a subsequent record of referral to a pulmonary rehabilitation programme (excluding those who have previously attended a pulmonary rehabilitation programme)	2	40-90%

COPD – rationale for inclusion of indicator set

- i. Chronic obstructive pulmonary disease (COPD) describes a group of lung conditions that cause obstructive airways disease and includes chronic bronchitis and emphysema. COPD is a common disabling condition responsible for significant unscheduled healthcare utilisation. When applicable, the most effective intervention is smoking cessation. Pulmonary rehabilitation has been shown to produce an improvement in quality of life and

decrease exacerbations. Inhaled bronchodilators and, in some cases, inhaled corticosteroids can be of benefit.

- ii. The majority of patients with COPD are managed by GPs and members of the primary care team with onward referral to secondary care when required. This indicator set focuses on the diagnosis and management of patients with symptomatic COPD.

COPD015 (based on NM169) – For the financial year 2024/25, this indicator is being income protected. The details of how this is applied are in section 2.1 of this document.

COPD015 Rationale

- i. The aim of this indicator is to encourage practices to maintain a register of patients with a diagnosis of COPD and to use that register of patients to inform the care they deliver, including objective testing to support diagnosis of COPD as recommended in NICE guidance NG115: Chronic obstructive pulmonary disease in over 16s: diagnosis and management⁵⁴. Linking diagnosis and objective testing to entry onto the QOF COPD disease register aims to contribute towards a reduction in both misdiagnosis and the risk of overtreatment in people with COPD. Referral to a specialist service may be appropriate for objective testing and to make an accurate diagnosis.

COPD015 Reporting and verification

- i. See indicator wording for requirement criteria. Patients with clinical diagnoses of COPD and no record of objective tests will not be excluded from the register but the expectation is that, over time, the proportion of patients with spirometry confirming fixed airflow obstruction will increase relative to those without spirometry recorded.
- ii. Where patients have co-existing COPD and asthma, they will be included on both disease registers.

COPD0010 (NICE 2019 menu ID: NM170)

⁵⁴NICE NG115 (2018, updated 2019) Chronic obstructive pulmonary disease in over 16s. <https://www.nice.org.uk/guidance/ng115>

COPD0010 Rationale

- i. This indicator aims to encourage the use of recording of number of exacerbations and assessments of breathlessness in annual COPD reviews and is supported by NICE guidance. Understanding the frequency of exacerbations can help when creating personalized management plans, identifying triggers and avoiding future exacerbations.
- ii. In making assessments of the patient's condition as part of an annual review and when considering management changes, it is essential that health care professionals record:
 1. Number of exacerbations
 2. The degree of breathlessness (Medical Research Council [MRC] dyspnoea scale).
 3. A tool such as the COPD Assessment Test (CAT) could be used to assess current health status.
- iii. Additionally, there is evidence that inhaled therapies can improve the quality of life in some patients with COPD. However, there is evidence that patients require training in inhaler technique and that such training requires reinforcement. Where a patient is prescribed an inhaled therapy, their technique is to be assessed face to face (or by video where that's not possible) during any review.
- iv. The MRC dyspnoea scale gives a measure of breathlessness and is recommended as part of the regular review. It is available in the NICE guideline on COPD, section 1.1, diagnosing COPD table one.

COPD0010 Reporting and verification

- i. See indicator wording for requirement criteria.

COPD014 (NICE 2012 menu ID: NM47) – For the financial year 2024/25, this indicator is being income protected. The details of how this is applied are in section 2.1 of this document.

COPD014 Rationale

- i. Pulmonary rehabilitation is a multidisciplinary programme of care which aims to reduce disability and improve quality of life in patients with a chronic

respiratory impairment. It is individually tailored and designed to optimise each patient's physical and social performance and independence.

- ii. The NICE guideline for COPD⁵⁵ recommends that pulmonary rehabilitation should be offered to all patients who consider themselves to be functionally disabled due to their COPD (usually MRC dyspnoea scale score of ≥ 3). Whilst most patients are likely to benefit, a rehabilitation programme is not suitable for patients who are unable to walk, have unstable angina or who have recently had a myocardial infarction.
- iii. Medical management should be optimised before referral.
- iv. The wording of this indicator has been updated to measure referrals made, not offers of referral.

COPD014 Reporting and verification

- i. See indicator wording for requirement criteria.
- ii. Patients who have previously attended a pulmonary rehabilitation programme will be excluded from the denominator for this indicator.
- iii. Where practices do not have locally commissioned pulmonary rehabilitation programmes they may exclude patients from the denominator using the specific service unavailable codes.

⁵⁵ NICE NG115 (2018, updated 2019) Chronic obstructive pulmonary disease in over 16s. <https://www.nice.org.uk/guidance/NG115>

3.11 Dementia (DEM)

Indicator	Points	Thresholds
Records		
DEM001. The contractor establishes and maintains a register of patients diagnosed with dementia	5	N/A
Ongoing management		
DEM004. The percentage of patients diagnosed with dementia whose care plan has been reviewed in the preceding 12 months	14	35–70%

DEM – rationale for inclusion of indicator set

- i. Dementia is a syndrome characterised by an insidious but ultimately catastrophic progressive global deterioration in intellectual function and is a main cause of late-life disability. The prevalence of dementia increases with age and is estimated to be approximately seven per cent in those over 65. Alzheimer’s disease accounts for around 50 to 75 per cent of cases of dementia with vascular dementia accounting for up to 20 per cent⁵⁶.

⁵⁶ Alzheimer’s Society (2020) Alzheimer’s Society’s view on demography.
<https://www.alzheimers.org.uk/about-us/policy-and-influencing/what-we-think/demography>

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- ii. The annual incidence of dementia of the Alzheimer's type rises to 34.3/100 person years at risk in the 90 year age group; the prevalence is higher in women than in men due to the longer lifespan of women. Other types of dementia such as Lewy Body dementia and frontotemporal dementia are relatively rare but can be very distressing.

DEM001 – For the financial year 2024/25, this indicator is being income protected. The details of how this is applied are in section 2.1 of this document.

DEM001 Rationale

- i. It is expected that the diagnosis will largely be recorded following patients being referred to secondary care with suspected dementia or as an additional diagnosis when a patient is seen in secondary care. However, it is also important to include patients where it is inappropriate or not possible to refer to a secondary care provider for a diagnosis and where the GP has made a diagnosis based on their clinical judgement and knowledge of the patient.

DEM001 Reporting and verification

- i. See indicator wording for requirement criteria.

DEM004 (NICE 2015 menu ID: NM107)

DEM004 Rationale

- i. The NICE guideline for dementia⁵⁷ recommends agreeing care plans with health and social services for people who have dementia, and having formal reviews at agreed frequencies.
- ii. Where a patient does not already have a care plan or an advanced care plan in place, it is expected that the practice will develop a care plan.
- iii. The care plan or advanced care plan review should be conducted face to face or remotely in line with personal choice and should focus on supporting the needs of the patient and their carer. Regular review can help ensure that any changes in need can be addressed. In particular the review should address the following key issues (in line with the D.E.M.E.N.T.I.A framework set out in

⁵⁷ NICE NG97 (2018) Dementia. <https://www.nice.org.uk/guidance/ng97>

NHS England's Dementia: Good personalised care and support planning guide):

- an appropriate physical, mental health and social review
 - a medication review, with particular attention to antipsychotic medication in consideration of:
 - side effects such as risk of diabetes and dyslipidaemia; and
 - anticholinergic effects in line with NICE guidance [NG97],
 - a record of the patients' wishes for the future
 - communication and co-ordination arrangements with secondary care (if applicable)
 - identification of the patients' carer(s)
 - appropriate permissions to authorise the practice to speak directly to the nominated carer(s) and provide details of support services available to the patient and their family, if applicable, the carer's needs for information commensurate with the stage of the illness and his or her and the patient's health and social care needs
 - as appropriate, the inclusion of the carer in the care plan or advanced care plan discussions
 - if applicable, the impact of caring on the care-giver
 - offering the carer a health check⁵⁸ to address any physical and mental health impacts, including signposting to any other relevant services to support their health and wellbeing
- iv. The practice will agree with the patient and their carer what is to be covered in the review and the duration of the consultation. Where appropriate, extended consultations may take up to 30 minutes⁵⁹. Ideally, the first such appointment would be within six months of diagnosis.
- v. A series of well-designed cohort and case control studies have demonstrated that patients with Alzheimer-type dementia do not complain of common physical symptoms but experience them to the same degree as the general

⁵⁸ Where the carer is registered at a different practice, the patients practice should inform the patient's carer that they can seek advice from their own practice.

⁵⁹ The practice should agree with the patient the most suitable length of this for this appointment, this could be provided as two 15 minute appointments if this is more appropriate for the patient.

population. Patient assessments therefore include the assessment of any behavioural changes caused by:

- concurrent physical conditions (e.g. joint pain or inter-current infections)
- new appearance of features intrinsic to the disorder (e.g. wandering) and delusions or hallucinations due to the dementia or as a result of caring behaviour (e.g. being dressed by a carer).

Depression could also be considered as it is more common in patients with dementia than those without⁶⁰.

- vi. Patients and carers are to be given relevant information about the diagnosis and sources of help and support (bearing in mind issues of confidentiality). Evidence suggests that healthcare professionals can improve satisfaction for carers by acknowledging and dealing with their distress and providing more information on dementia⁶¹. As the illness progresses, needs may change, and the review may focus more on issues such as respite care.
- vii. There is good evidence from well-designed cohort studies and case control studies of the benefit of healthcare professionals asking about the impact of caring for a person with dementia and the effect this has on the caregiver. It is important to remember that male carers are less likely to complain spontaneously and that the impact of caring is dependent not on the severity of the cognitive impairment but on the presentation of the dementia, for example, on factors such as behaviour and affect. If the carer is not registered at the practice but the GP is concerned about issues raised in the consultation, then, with appropriate permissions, they can contact the carer's own GP for further support and treatment.
- viii. As the illness progresses and more agencies are involved, the review could additionally focus on assessing the communication between health and social care and non-statutory sectors as appropriate, to ensure that potentially complex needs are addressed. Communication and referral issues highlighted in the review need to be followed up as part of the review process.

Further information:

- NICE NG97 (2018) Dementia. <https://www.nice.org.uk/guidance/ng97>
- NICE QS184 (2019) Dementia. <https://www.nice.org.uk/guidance/qs184>

⁶⁰ Alzheimer's society: Apathy, anxiety and depression. 2017

⁶¹ Eccles et al. BMJ 1998; 317: 802-808

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- Forget me not dementia training. <http://www.forgetmenotdementia.co.uk/>
 - NSF for Older People. 2001. http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_4003066
 - NICE PH16 (2008) Mental wellbeing in over 65s: occupational therapy and physical activity interventions. <https://www.nice.org.uk/guidance/ph16>
 - NHS Choices. Looking after someone with dementia. 2015. <https://www.nhs.uk/conditions/dementia/carers/>

DEM004 Reporting and verification

- i. See indicator wording for requirement criteria.
- ii. Verification – Commissioners may require randomly selecting a number of patient records of patients in which the review has been recorded as taking place to confirm that the four key issues are recorded as having been addressed, if applicable.

3.12 Depression (DEP)

Indicator	Points	Thresholds
Initial management		
DEP004. The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis	10	45–80%

DEP – rationale for inclusion of the indicator set

- i. Depression is common and disabling.
- ii. The Adult Psychiatric Morbidity Survey, 2014⁶² estimated prevalence for a depressive episode among people aged 16 in England was 3.3 per cent. If the broader and less specific category of mixed depression and anxiety ('common mental health disorder – not otherwise stated') is included, these figures increase dramatically to 7.8 per cent. It contributes 12 per cent of the total burden of non-fatal global disease and by 2020, looks set to be second after CVD in terms of the world's disabling diseases⁶³. Major depressive disorder is increasingly seen as chronic and relapsing, resulting in high levels of personal disability, lost quality of life for patients, their family and carers, multiple morbidity, suicide, higher levels of service use and many associated economic costs. In 2007, the total cost of depression in England was reported to be £7.5 billion of which health service costs comprised £1.7 billion and lost earnings £5.8 billion. When the cost of informal care, lower productivity and

⁶² <https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-of-mental-health-and-wellbeing-england-2014>

⁶³ Murray CJ. Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990–2010: a systematic analysis for the global burden of disease study 2010. *Lancet*. 2012;380(9859):2197–223.

other public sector costs are included this figure is estimated at between £20.2-23.8 billion a year⁶⁴.

DEP004 (based on NICE 2012 menu ID: NM50) – For the financial year 2024/25, this indicator is being income protected. The details of how this is applied are in section 2.1 of this document.

DEP004 Rationale

- i. This indicator promotes a single depression review between ten and 56 days inclusive after the date of diagnosis. The NICE guideline on depression in adults⁶⁵ states that all patients with a new episode of depression should normally be reviewed within two to four weeks to see how well treatment is working or as part of active monitoring. For some patients this may not be their first review: patients starting antidepressants aged 18 to 25 years or thought to be at increased risk of suicide should be reviewed after one week. Patients are then re-assessed at regular intervals determined by their response to treatment and whether or not they are considered to be at an increased risk of suicide. Unless a patient's symptoms have resolved, further reviews may be required.
- ii. When assessing a person who may have depression, conduct a comprehensive assessment that does not rely simply on a symptom count but also takes into account severity of symptoms, previous history, duration and course of illness. Also, take into account both the degree of functional impairment and/or disability associated with the possible depression and the duration of the episode.
- iii. Only face-to-face or telephone contact with a clinician is acceptable to meet the requirements for this indicator.

DEP004 Reporting and verification

- i. See indicator wording for requirement criteria.
- ii. Those patients whose on-going care is being provided by specialist mental health services may have a personalised care adjustment applied.

⁶⁴ DH. No health without mental health – supporting document. 2011.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

⁶⁵ NICE NG222 (2022) Depression in adults: recognition and management.

<https://www.nice.org.uk/guidance/NG222>

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- iii. It is recommended that where the diagnosis is made by specialist mental health services and the patient has been discharged for follow-up by the primary care team, the contractor should find out the diagnosis date in order to record this and invite the patient for a review within the timeframe specified.
 - iv. Suspected depression seen in secondary care may not always be referred to specialist mental health services for further assessment and management. It may be in the form of a discharge letter from an acute medical or surgical ward, A&E, or from an outpatient appointment. It may be reasonable in these circumstances for a contractor to contact the patient to ask them to attend for an assessment to assess if they have a clinical diagnosis of depression.
 - v. The register (DEPCC01), for the purpose of calculating the APDF, is defined as number of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March or with a new diagnosis of depression in the last 3 months of the previous QOF year and did not achieve in the previous QOF year.
 - vi. Verification – Commissioners may ask contractors about the percentage of telephone reviews conducted and who they were delivered by.

3.13 Mental health (MH)

Indicator	Points	Thresholds
Records		
MH001. The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy	4	N/A
Ongoing management		
MH002. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate	5	40–90%
MH003. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months	3	50–90%
MH006. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months	3	50-90%
MH007. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months	3	50-90%
MH011. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of a lipid profile in the preceding 12 months (in those patients currently prescribed antipsychotics, and/or have pre-existing cardiovascular conditions, and/or smoke, and/or are overweight (BMI of ≥ 23 kg/m ² or ≥ 25 kg/m ² if ethnicity is recorded as White) or preceding 24 months for all other patients	7	50-90%
MH012. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months	7	50-90%
MH021: Percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who received all six elements of the Physical Health Check for people with Severe Mental Illness	6	50-80%

MH – rationale for inclusion of indicator set

- i. This indicator set reflects the complexity of mental health problems, and the complex mix of physical, psychological and social issues that present to GPs.
- ii. For many patients with mental health problems, the most important aspects of care quality relate to the interpersonal skills of the doctor, the time given in consultations and the opportunity to discuss a range of management options.
- iii. This indicator set focuses on patients with severe mental illness (SMI). There are separate indicator sets that focus on patients with depression and dementia.
- iv. An important aim of the indicator set is to help address a major health inequality experienced by people with SMI reflected in a reduced life expectancy of around 10-20 years.⁶⁶ Although a UK study found some evidence of decreasing all-cause mortality rates in people with SMI, when compared with a matched general population the life expectancy gap is still widening suggesting that the improvement in the health of the general population is increasing more rapidly than for those with SMI and the health inequality may be worsening.⁶⁷ Another UK study found that almost 80% of the life expectancy gap could be attributed to common physical problems such as cardiovascular, respiratory, cancer, metabolic and infectious disorders; of these, cardiovascular disease (CVD) was the largest single contributor.⁶⁸

NICE CG178⁶⁹ recommends that primary care utilise registers to monitor the physical health of patients with psychosis or schizophrenia. The health check should be comprehensive, focusing on physical health problems that are common in people with psychosis and schizophrenia. NICE recommends health checks should include the following:

- weight (plotted on a chart)
- waist circumference
- pulse and blood pressure

⁶⁶ Laursen TM. Life expectancy among persons with schizophrenia or bipolar affective disorder. *Schizophr Res* 2011; 131: 101–4).

⁶⁷ Hayes, J. F., Marston, L., Walters, K., King, M. B., & Osborn, D. P. J. (2017). Mortality gap for people with bipolar disorder and schizophrenia: UK-based cohort study 2000–2014. *British Journal of Psychiatry*, **211**(3), 175–181.

⁶⁸ Jayatilleke, N., Hayes, R. D., Dutta, R., Shetty, H., Hotopf, M., Chang, C.-K., & Stewart, R. (2017). Contributions of specific causes of death to lost life expectancy in severe mental illness. *European Psychiatry*, **43**, 109–115

⁶⁹ NICE CG178 (2014) Psychosis and schizophrenia in adults.
<http://www.nice.org.uk/guidance/CG178>

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- fasting blood glucose or glycosylated haemoglobin (HbA1c)
 - blood lipid profile and prolactin levels
 - assessment of any movement disorders
 - assessment of nutritional status, diet and level of physical activity
- v. NICE CG185⁷⁰ recommends that patients with bipolar affective disorder have a physical health review, normally in primary care, performed at least annually, including the following health checks:
- weight or BMI, diet, nutritional status and level of physical activity
 - cardiovascular status, including pulse and blood pressure
 - metabolic status, including glycosylated haemoglobin (HbA1c) and blood lipid profile
 - liver function
 - renal and thyroid function, and calcium levels, for people taking long-term lithium
- vi. QOF rewards practices for delivering all six elements of a full annual physical health check for patients with schizophrenia, bipolar affective disorder and other psychoses as defined in the NHS Long Term Plan. A key focus of the health check is to identify those individuals with risk factors for cardiovascular disease (CVD) and type 2 diabetes, given these disorders are 2-3x more common than in the general population and are major contributors to the life expectancy gap.⁷¹ Moreover, high rates of CVD and type 2 diabetes can be predicted by high rates of metabolic syndrome; this confirms the tendency for this population to experience clustering of obesity, hypertension, glucose and lipid disturbances, and are caused by an accumulative impact of adverse metabolic effects from psychotropic medication and poor health behaviours (poor diet, physical inactivity).⁷² These risks are further compounded by substantially higher rates of smoking than the general population.⁷³ Providing

⁷⁰ NICE CG185 (2014, updated 2023) Bipolar disorder: assessment and management.

<http://www.nice.org.uk/guidance/CG185>

⁷¹ Ma R, Romano E, Ashworth M, Yadegarfar ME, Dregan A, Ronaldson A, de Oliveira C, Jacobs R, Stewart R, Stubbs B. Multimorbidity clusters among people with serious mental illness: a representative primary and secondary data linkage cohort study. *Psychol Med.* 2023 Jul;53(10):4333-4344. doi: 10.1017/S003329172200109X.)

⁷² Vancampfort D, Stubbs B, Mitchell AJ, De Hert M, Wampers M, Ward PB, Rosenbaum S, Correll CU. Risk of metabolic syndrome and its components in people with schizophrenia and related psychotic disorders, bipolar disorder and major depressive disorder: a systematic review and meta-analysis. *World Psychiatry.* 2015 Oct;14(3):339-47

⁷³ Szatkowski L, McNeill A. Diverging trends in smoking behaviors according to mental health status. *Nicotine Tob Res* 2014; 17: 356–60.

a full annual check is therefore important when considering the collective impact of these risk factors.

Further information

NICE CG178 (2014) Psychosis and schizophrenia in adults.

<https://www.nice.org.uk/guidance/cg178>

Practices may wish to utilise [the Lester tool](#); a mental health physical review template <https://www.tpp-uk.com/mhpr>

MH001

MH001 Rationale

- i. The register includes all patients with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy.
- ii. For clarification, patients who are coded onto MH1_REG (patients with schizophrenia, bipolar, other psychosis etc) are offered a physical health check, patients who are coded onto the MH2_REG (those on lithium therapy) are not offered a physical health check. Most patients under MH2_REG who are on lithium therapy will also have a SMI diagnosis and will also be under MH1_REG.

Remission from severe mental illness

- i. Historically, patients have been added to the mental health disease register for schizophrenia, bipolar affective disorder and other psychoses, but over time it has become apparent that it would be appropriate to exclude some patients from the associated indicators because their illness is in remission.
- ii. Making an accurate diagnosis of remission for a patient with a diagnosis of severe mental illness can be challenging and the evidence base to support when to use the 'remission code' is largely based on clinical judgement. A longitudinal international study of recovery from psychotic illnesses found that as many as 56% of patients recovered from psychotic illnesses to some

extent, although only 16% recover if a more stringent concept of recovery⁷⁴ is used.

- iii. In the absence of strong evidence of what constitutes 'remission' from severe mental illness, it is advised that 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 antipsychotic or mood stabiliser medication
 - no mental health in-patient episodes
 - no secondary care mental health follow-up
- iv. Where a patient is recorded as being 'in remission', they remain on the register (in case their condition relapses at a later date) but they are excluded from the denominator for subsequent indicators (i.e. they are excluded from the denominator for MH002, MH003, MH006, MH007, MH011, MH012 and SMOK002).
- v. The accuracy of this diagnosis and the coding should be reviewed on an annual basis by a clinician. If a patient who has been coded as 'in remission' experiences a relapse then this should be recorded as such in their patient record.
- vi. 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.

MH001 Reporting and verification

- i. See indicator wording for requirement criteria.
- ii. Verification – Commissioners may require randomly selecting a number of patient records in which a 'remission code' has been recorded and request evidence as to why it was appropriate for that patient to be considered 'in remission'.

68 Harrison G, Hopper K, Craig T, Laska E, Siegel C, Wanderling J et al. Recovery from psychotic illness: A 15 and 25 year international follow-up study. 2001. *BJP*, 178: 506-517

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- iii. Contractors may be expected to demonstrate they have a protocol to guide their clinicians **on the process** and who would be suitable to make the decision. It would not be appropriate for non-clinical members of the practice to make the decision **on applying a remission** code.

MH002 (NICE 2015 menu ID: NM108)

MH002 Rationale

- i. This indicator reflects good professional practice and is supported by NICE CG178⁷⁵ and CG185⁷⁶.
- ii. Patients on the mental health disease register should have a documented primary care consultation that acknowledges, especially in the event of a relapse, a plan for care. This consultation **should consider** the views of relative(s) or carer(s) where appropriate.
- iii. For patients **that are discharged from secondary care**, it is important that the primary care team takes responsibility for discussing and documenting a care plan in their primary care record.
- iv. If a patient is treated within community mental health services and has a documented care plan, this is acceptable for the purposes of QOF provided the practice has evidence of a review having taken place⁷⁷.
- v. 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.

MH002 Reporting and verification

- i. See indicator wording for requirement criteria.
- ii. Verification – Commissioners may require contractors to randomly select a number of care plans to ensure that they are being **reviewed** annually **and updated where necessary**.

⁷⁵ NICE CG178 (2014). Psychosis and schizophrenia in adults.

<http://www.nice.org.uk/guidance/CG178>

⁷⁶ NICE CG185 (2014, updated 2023) Bipolar disorder. <https://www.nice.org.uk/guidance/cg185>

⁷⁷ Community Mental Health Framework replaced CPA. <https://www.england.nhs.uk/publication/care-programme-approach-position-statement/>

MH003, MH006, MH007, M011 and MH012 (based on NM17, NM16, NM15, NM129, NM130 respectively)

MH003, MH006, MH007, M011 and MH012 Rationale

- i. NICE guidance^{78,79} recommends annual monitoring of blood pressure for people with bipolar disorder, psychosis or schizophrenia. Patients with schizophrenia have mortality rates that are two to three times higher than that of the general population and the majority of the excess deaths are preventable. A prospective record linkage study of the mortality of a community cohort of 370 patients with schizophrenia found that the increased mortality risk is probably life-long and it suggested that the cardiovascular mortality of people with schizophrenia has increased over the past 25 years relative to the general population⁸⁰. The NICE guideline on bipolar disorder also states that the standardised mortality ratio for cardiovascular death may be twice that of the general population but appears to be reduced if patients adhere to long-term medication.
- ii. There is evidence to suggest that physical conditions such as cardiovascular disorders go unrecognised in psychiatric patients. A direct comparison of cardiovascular screening (blood pressure, lipid levels and smoking status) of patients with asthma, schizophrenia and other attendees indicated that general practice were less likely to screen patients with schizophrenia for cardiovascular risk compared with the other two groups⁸¹.
- iii. Recording (and treating) cardiovascular risk factors is therefore very important for patients with a severe mental illness.
- iv. MH007 incentivises delivering the requirement to record alcohol intake as part of the physical check. Alcohol and other substance misuse by people with schizophrenia is increasingly recognised as a major problem, both in terms of its prevalence and its clinical and social effects⁸². The National Psychiatric Morbidity Survey in England found that 16% of people with schizophrenia were drinking above the lower risk consumption levels (14 units) of

⁷⁸ NICE CG178 (2014). Psychosis and schizophrenia in adults.

<http://www.nice.org.uk/guidance/CG178>

⁷⁹ NICE CG185 (2014, updated 2020) Bipolar disorder. <https://www.nice.org.uk/guidance/cg185>

⁸⁰ Brown S, Kim M, Mitchell C et al. 25 year mortality of a community cohort with schizophrenia. *BJP*. 2010. 196: 116-21.

⁸¹ Roberts L, Roalfe A, Wilson S et al. Physical health care of patients with schizophrenia in primary care: a comparative study. 2007. *FamPract* 24: 34-40

⁸² RCP Research and Training Unit. Banerjee S, Clancy C, Crome I, editors. Co-existing problems of mental disorder and substance misuse (dual diagnosis). 2001. Information manual.

alcohol^{83,84}. Bipolar affective disorder is also highly co-morbid with alcohol and other substance abuse.

- v. NICE guidance^{85,86} recommends annual monitoring of blood glucose or HbA1c for people with bipolar disorder, psychosis or schizophrenia. Diabetes is 2–3 times more common among people with SMI than the general population⁸⁷ and antipsychotic medication can be diabetogenic⁸⁸. The National Diabetes Audit confirms previous studies that type 2 diabetes is twice as common among people with SMI than in the general population. The rates of type 1 diabetes are about the same as the general population, although the overall numbers are small. People with SMI are more likely to develop type 2 diabetes earlier than the general population, frequently in the fourth and fifth decades. People with an SMI are more likely to develop type 1 diabetes later than those without a SMI, as late as the third and fourth decades of life⁸⁹.

MH003, MH006, MH007, M011 and MH012 Reporting and verification

- i. See indicator wording for requirement criteria.
- ii. Within the business rules currently being prescribed an antipsychotic medication is defined as a prescription in the preceding 6 months; pre-existing cardiovascular conditions are defined as CHD, diabetes, stroke, peripheral arterial disease and chronic kidney disease; being a current smoker is defined as a patient whose notes record smoking status in the preceding 12 months and being overweight is defined as latest BMI of ≥ 23 kg/m² or ≥ 25 kg/m² if ethnicity is recorded as white.
- iii. Patients who have a diagnosis of diabetes will be excluded from MH012.

⁸³ Meltzer H, Gill B, Pettigrew M et al. OCPS Survey of Psychiatric Morbidity in GB. Report 3: Economic activity and social functioning of adults with psychiatric disorders. 1996.

⁸⁴ Farrell M, Howes S, Taylor C et al. Substance misuse and psychiatric co-morbidity: an overview of the OCPS National Psychiatric Morbidity Survey. *Addictive behaviours* 23: 909-18. 1998.

⁸⁵ NICE CG178 (2014). Psychosis and schizophrenia in adults.

<http://www.nice.org.uk/guidance/CG178>

⁸⁶ NICE CG185 (2014, updated 2020) Bipolar disorder. <https://www.nice.org.uk/guidance/cg185>

⁸⁷ Vinogradova Y, Coupland C, Hippisley-Cox J, et al. (2010) Effects of severe mental illness on survival of people with diabetes. *Br J Psychiatry* 197(4):272–277.

⁸⁸ Smith M, Hopkins D, Peveler RC, et al. (2008) First- vs. second-generation antipsychotics and risk for diabetes in schizophrenia: systematic review and meta-analysis. *Br J Psychiatry* 192(6):406–411.

⁸⁹ <https://bjgp.org/content/68/669/166#xref-ref-4-1>

MH021 (based on NICE NM232) – For the financial year 2024/25, this indicator is being income protected. The details of how this is applied are in section 2.1 of this document.

MH021 Rationale

- i. See rationale for MH002, MH006, MH007, MH011, MH012 and SMOK002 and the following NICE guidance referenced (CG178⁹⁰ and CG185⁹¹).
- ii. Good clinical practice in this area as a minimum consists of a single coordinated physical health review of the patient made up of six components, supporting a 'Making Every Contact Count' approach, which provides better service user experience by reducing the need for multiple appointments.

MH021 Reporting and verification

- i. See indicator wording for requirement criteria.

3.14 Cancer (CAN)

Indicator	Points	Thresholds
Records		
CAN001. The contractor establishes and maintains a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers diagnosed on or after 1 April 2003'	5	N/A
Ongoing management		
CAN004. The percentage of patients with cancer, diagnosed within the preceding 24 months, who have a patient Cancer Care Review using a structured template recorded as occurring within 12 months of the date of diagnosis	6	50–90%
CAN005. The percentage of patients with cancer, diagnosed within the preceding 12 months, who have had	2	70-90%

⁹⁰ NICE CG178 (2014) Psychosis and schizophrenia in adults.

<http://www.nice.org.uk/guidance/cg178>

⁹¹ NICE CG185 (2014, updated 2023) Bipolar disorder.

<http://www.nice.org.uk/guidance/cg185>

the opportunity for a discussion and informed of the support available from primary care, within 3 months of diagnosis		
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CAN – rationale for inclusion of indicator set

- i. It is recognised that the principal active management of cancers occurs in the secondary care setting. However, general practice has a key role in the referral and/or subsequent support of these patients and in ensuring that care is appropriately co-ordinated. This indicator set is not evidence-based but does represent good professional practice.
- ii. These indicators for cancer aim to increase the personalisation of cancer care and the timing of the cancer care review.

CAN001

CAN001 Rationale

- i. The register can be developed prospectively as the intention is to ensure appropriate care and follow-up for patients with a diagnosis of cancer. For the purposes of the register all cancers are included except non-melanomatous skin lesions.

CAN001 Reporting and verification

- i. See indicator wording for requirement criteria.

CAN005 (based on NM204) – For the financial year 2024/25, this indicator is being income protected. The details of how this is applied are in section 2.1 of this document.

CAN005 Rationale

- i. Most practices will see patients with a new cancer diagnosis following assessment and management in a secondary or tertiary care setting. This indicator aims to encourage GP practices to proactively provide patients with the opportunity for a discussion to make them aware of the support available from their GP and wider practice team. The intention is to facilitate early and supportive conversations and ensure patients are aware of what help is available.

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- ii. This indicator supports recommendations 1.1.1, 1.3.4 and 1.3.5 from NICE guideline CG138 Patient experience in adult NHS services.⁹²

CAN005 Reporting and verification

- i. See indicator wording for requirement criteria.
- ii. For the purposes of this indicator, the twelve-month timeframe starts from the date of diagnosis irrespective of whether or not the diagnosis was made in primary care.

CAN004 (NICE menu 2020 ID: NM205) – For the financial year 2024/25, this indicator is being income protected. The details of how this is applied are in section 2.1 of this document.

CAN004 Rationale

- i. A GP will have an average of eight or nine new cancer diagnoses per year and will be looking after 20 to 30 patients with cancer. The increasing number of cancer survivors has led to an increase in the number of people requiring follow-up care, monitoring and management, therefore primary care has an important role in supporting people to live well with and beyond cancer. This review represents an opportunity to address patients' needs for individual assessment, care planning and on-going support and information requirements.
- ii. The Cancer Care Review should be a holistic conversation that covers clinical, practical, emotional, psychological and financial (where appropriate) aspects of the person's cancer care. The clinical element of the review should be conducted by a GP, General Practice Nurse, or Allied Health Professional. The use of non-clinical supporting roles should be underpinned by robust links to clinical teams and appropriate training and supervision should be provided. Consideration of the co-ordination of care between sectors is recommended. Practices should use Macmillan's national, integrated electronic CCR template within your Primary Care IT system to support a well-structured review. Further information on how to access Macmillan's CCR templates on all major GP IT systems can be found on the Macmillan website.⁹³

⁹² NICE CG138 (2012, updated 2021) Patient experience in adult NHS services.

<https://www.nice.org.uk/guidance/cg138>

⁹³ <https://www.macmillan.org.uk/healthcare-professionals/innovation-in-cancer-care/personalised-care#reviews>

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- iii. This template can be used as an aide memoire when carrying out a CCR. It also includes supporting information which can be shared with the patient as well as providing a helpful coded record of topics discussed.
 - iv. Macmillan also provides Top Tips on Cancer Care Reviews⁹⁴ which encourages a fuller discussion of the diagnosis and recording of cancer therapy, an offer of relevant information, medication review, benefits counselling and recording of a carer's details. Macmillan 'Top Tips' guides on late effects, fatigue, anxiety, nutrition and other common problems are also available⁹⁵. Further information on care following a cancer diagnosis and the potential role for primary care can be found on the Macmillan website⁹⁶.

CAN004 Reporting and verification

- i. See indicator wording for requirement criteria.
- ii. For the purposes of this indicator, the twelve-month timeframe starts from the date of diagnosis irrespective of whether or not the diagnosis was made in primary care.
- iii. Verification – Commissioners may wish to review records where a review is claimed to confirm that the review has been completed using a structured template within twelve months of diagnosis.

⁹⁴ [10 top tips for primary care: Cancer Care Reviews | Macmillan Cancer Support](#)

⁹⁵ [Guides | Healthcare professionals | Macmillan Cancer Support](#)

⁹⁶ <https://www.macmillan.org.uk/about-us/health-professionals/resources/resources-for-gps.html>

3.15 Chronic kidney disease (CKD)

Indicator	Points	Thresholds
Records		
CKD005. The contractor 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)	6	N/A

CKD – rationale for inclusion of indicator set

- iii. NICE guidance⁹⁷ recommends classifying CKD using a combination of glomerular filtration rate (GFR) and albumin creatinine ratio (ACR), see description in table 1.
- iv. The [Health Survey for England](#) (2016)¹⁰⁶ found that 13% of adults (16 years and over) had any CKD (stages 1 to 5). The prevalence of stages 3 to 5 was 5% for all adults, rising to 34% in people aged 75 and over. At the end of 2018 there were 826 children and young people and 66,612 adults receiving renal replacement therapy in the UK according to the [UK Renal Registry annual report](#)¹⁰⁷.
- v. This indicator applies to patients with category G3a, G3b, G4 and G5 CKD (GFR<60 ml/min/1.73 m² on at least 2 occasions separated by a period of at least 90 days).
- vi. Late presentation of patients with kidney failure increases morbidity, mortality and healthcare associated with costs. **The total annual economic burden of kidney disease in the UK is £7.0 billion, with £6.4 billion being direct costs to the NHS – about 3.2% of NHS budgets. The total cost of kidney disease is predicted to increase from 7 billion in 2023 to £7.8 billion by 2033 (11% increase from 2023). Increasing prevalence of CKD 3-5 will be the biggest driver in costs.**⁹⁸
- vii. Early identification of CKD is therefore important to not only allow appropriate measures to be taken to slow or prevent the progression to more serious CKD, but also to highlight and manage the key associated risks related to patient safety and avoidable harm. **NICE approved Sodium-glucose cotransporter 2 inhibitors (SGLT2is) can potentially minimise loss of kidney function and further progression of kidney disease. It is advised that systems**

⁹⁷ NICE NG203 (2021) Chronic kidney disease. <https://www.nice.org.uk/guidance/ng203>

⁹⁸ Kidney disease : A UK public health emergency The health economics of kidney disease to 2023 Kidney Research UK, <https://www.kidneyresearchuk.org/>

consider procurement and prescribing of these where patients are identified through ACR testing to be suitable for these.⁹⁹

Table 1. Classification of CKD using GFR and ACR categories

	ACR category A1: normal to mildly increased (less than 3 mg/mmol)	ACR category A2: moderately increased (3 to 30 mg/mmol)	ACR category A3: severely increased (over 30 mg/mmol)
GFR category G1: normal and high (90 ml/min/1.73 m² or over)	Low risk No CKD if there are no other markers of kidney damage	Moderate risk	High risk
GFR category G2: mild reduction related to normal range for a young adult (60 to 89 ml/min/1.73 m²)	Low risk No CKD if there are no other markers of kidney damage	Moderate risk	High risk
GFR category G3a: mild to moderate reduction (45 to 59 ml/min/1.73 m²)	Moderate risk	High risk	Very high risk
GFR category G3b: moderate to severe reduction (30 to 44 ml/min/1.73 m²)	High risk	Very high risk	Very high risk
GFR category G4: severe reduction (15 to 29 ml/min/1.73 m²)	Very high risk	Very high risk	Very high risk

CKD005 (NICE 2014 menu ID: NM83) – For the financial year 2024/25, this indicator is being income protected. The details of how this is applied are in section 2.1 of this document.

CKD005 Rationale

- i. This indicator aims to establish a register of people with CKD categories G3a to G5 to enable appropriate advice, treatment and support to be provided for people with moderate to severe CKD and so help preserve kidney function and reduce the risk of developing co-morbidity.

⁹⁹ Meraz-Muñoz, Alejandro Y.; Weinstein, Jordan; Wald, Ron *Kidney360* 2(6):1042-1047, June 2021

- ii. Eating a meal containing protein can elevate creatinine, therefore it is recommended that patients do not eat meat in the 12 hours before their creatinine is measured and glomerular filtration rate estimated.

CKD005 Reporting and verification

- i. See indicator wording for requirement criteria.

3.16 Epilepsy (EP)

Indicator	Points	Thresholds
Records		
EP001. The contractor establishes and maintains a register of patients aged 18 or over receiving drug treatment for epilepsy.	1	N/A

EP – rationale for inclusion of indicator set

- i. Epilepsy is the most common serious neurological condition, affecting about five to ten per 1000 of the population at any one time. Few epilepsies are preventable, but appropriate clinical management can enable most patients with epilepsy to lead a full and productive life. For the purposes of QOF, epilepsy is defined as 'recurrent unprovoked seizures'.

EP001 – For the financial year 2024/25, this indicator is being income protected. The details of how this is applied are in section 2.1 of this document.

EP001 Rationale

- i. The disease register includes patients aged 18 or over, as care for younger patients is generally undertaken outside of primary care.
- ii. The phrase 'receiving treatment' has been included in order to exclude the large number of patients who may have had epilepsy in the past, may have not received treatment and been fit-free for many years. Some patients may still be coded as 'epilepsy' or 'history of epilepsy' and will be picked up on computer searches.
- iii. Patients with a history of epilepsy who are not on drug therapy are excluded from the register. Drugs on repeat prescription will be picked up on a search.

EP001 Reporting and verification

- i. See indicator wording for requirement criteria.
- ii. Verification – Commissioners may require a comparison of the expected prevalence with the reported prevalence recognising that reported prevalence will be reduced as the register is limited to those patients receiving drug treatment.

3.17 Learning disabilities (LD)

Indicator	Points	Thresholds
Records		
LD004. The contractor establishes and maintains a register of patients with learning disabilities	4	N/A

LD – rationale for inclusion of indicator set

- i. There is a significant health inequalities gap for people with a learning disability. 42% of deaths of people whose deaths were reviewed through LeDeR in 2022 were of an avoidable (as defined by ONS¹⁰⁰) cause compared to 22% in the general population. The median age of death for those whose deaths were reported to LeDeR in 2022 was 62.9 years of age.¹⁰¹
- ii. There are estimated to be 1.3 million people with a learning disability in England. The number of people with a learning disability recorded in health and welfare systems is much lower¹⁰².
- iii. In data published in December 2023, covering 55.1% of patients registered with a GP in England, 0.5% were recorded by their GP as having a learning disability in 2022/23.¹⁰³
- iv. People with a learning disability may not recognise they are unwell or be unable to communicate how they feel. There can also be an increased risk of diagnostic overshadowing¹⁰⁴. 46% of adults with a learning disability whose

¹⁰⁰ [Avoidable mortality in the UK - Office for National Statistics \(ons.gov.uk\)](#)

¹⁰¹ [Learning from Lives and Deaths - people with a learning disability and autistic people \(LeDeR\) - King's College London \(kcl.ac.uk\)](#)

¹⁰² [Prevalence | Background information | Learning disabilities | CKS | NICE](#)

¹⁰³ [Health and Care of People with Learning Disabilities, Experimental Statistics 2022 to 2023 - NHS Digital](#)

¹⁰⁴ ['Diagnostic Overshadowing' Amongst Clinicians Working with People with Intellectual Disabilities in the UK - Mason - 2004 - Journal of Applied Research in Intellectual Disabilities - Wiley Online Library](#)

deaths were reviewed by LeDeR had between 7 and 10 long term conditions when they died.¹⁰⁵

LD004 (NICE 2015 menu ID: NM73) – For the financial year 2024/25 this indicator is being income protected, the details of how this is applied are in section 2.1 of this document.

LD004 Rationale

- i. This register indicator includes people of any age with a learning disability. This is because without a complete register of people with a learning disability, practices may not be aware of the amount of people that may require reasonable adjustments¹⁰⁶, and of the help and support that may be useful to them. In order to ensure accurate recording, primary care will need to liaise with the wider health, education and social care network to identify and include onto the register a child, young person or adult, with the aim to improve health outcomes through identification and early intervention to prevent the onset of clinical conditions and comorbidities over the life of the person, utilising the guidance¹⁰⁷ to improving identification of people with a learning disability where a diagnosis is not provided.
- ii. Evidence suggests that the prevalence of children with a recorded learning disability is increasing, alongside a reduction in mortality for children with a learning disability.¹⁰⁸ There is an increased prevalence of a number of health conditions and impairments in children with a learning disability¹⁰⁹ Health services are often unprepared to address the needs of children and young people with as they transition into adulthood¹¹⁰.
- iii. A full register of patients with learning disabilities and their ethnicity will provide primary care practitioners with the first important building block in providing better quality and more appropriate services for this patient

¹⁰⁵ LeDeR - Annual reports (2020)

¹⁰⁶ Reasonable Adjustment Flag - NHS Digital

¹⁰⁷ NHS England » Improving identification of people with a learning disability: guidance for general practice

¹⁰⁸ Emerson, E. Estimating Future Numbers of Adults with Profound learning disabilities in England. 2009. <http://www.emeraldinsight.com/doi/abs/10.1108/13595474200900040?journalCode=tldr>

¹⁰⁹ Health inequalities experienced by children and young people with intellectual disabilities: a review of literature from the United Kingdom - PubMed (nih.gov)

¹¹⁰ Betz, C. Transition of Adolescents with Special Health Care Needs: review and analysis of the literature. 2004. Issues in Comprehensive Paediatric Nursing 27:179–241

population. The Race Health observatory reported the median age of death of a person with a learning disability from a minority ethnic community is 34.¹¹¹

- iv. Learning disabilities are heterogeneous conditions, but are defined by three core criteria:
 - a) Lower intellectual ability (usually defined as an Intelligence Quotient [IQ] of less than 70) or a significantly reduced ability to understand new or complex information;
 - b) Significant impairment of social or adaptive functioning; and
 - c) Onset in childhood.
- v. An IQ below 70 should not be used on its own to determine whether someone has a learning disability. The definition encompasses people with a broad range of disabilities. It includes adults with autism who also have learning disabilities, but not people with a higher level autistic spectrum disorder who may be of average or above average intelligence. The definition does not include all those people who have a “learning difficulty”, e.g. specific difficulties with learning, such as dyslexia.
- vi. NHS England has published guidance¹¹² aimed at improving the identification of people with a learning disability. Practices should review this guidance and update their registers at least annually to ensure that they are accurate. Practices should refer to the table in appendix four ‘learning disability identification check-list’ of this guidance, to assist them in identifying a person with a learning disability.
- vii. It is a statutory requirement under the Equality Act 2010 that public sector agencies make ‘reasonable adjustments’ to their practice that will make them as accessible and effective as they would be for people without disabilities. Reasonable adjustments include removing physical barriers to accessing health services, but importantly also include making whatever alterations are necessary to information, policies, procedures, staff training, communication interventions and service delivery to ensure that they work equally well for people with learning disabilities¹¹³. The introduction of the reasonable adjustment digital flag¹¹⁴ held on the NHS Spine, enables health and care

¹¹¹ We deserve better: Ethnic Minorities with a Learning Disability and Access to Healthcare - NHS – Race and Health Observatory (nhsrho.org) Part A

¹¹² NHS England. 2019. Improving identification of people with a learning disability: guidance for general practice. <https://www.england.nhs.uk/wp-content/uploads/2019/10/improving-identification-of-people-with-a-learning-disability-guidance-for-general-practice.pdf>

¹¹³ PHE. Making reasonable adjustments to eye care services for people with learning disabilities. 2013. <http://www.improvinghealthandlives.org.uk/publications.php5?rid=1167&edit>

¹¹⁴ [DAPB4019: Reasonable Adjustment Digital Flag - NHS Digital](#)

professionals to record, share and view details of reasonable adjustments across the NHS, wherever the person is treated.

LD004 Reporting and verification

- i. See indicator wording for requirement criteria.
- ii. Where practices are cautious to add a code where there is no confirmed diagnosis, they are encouraged to use the code 'on the LD register'.

3.18 Osteoporosis: secondary prevention of fragility fractures (OST)

Indicator	Points	Thresholds
Records		
OST004. The contractor establishes and maintains a register of patients: <ol style="list-style-type: none"> 1. Aged 50 or over and who have not attained the age of 75 with a record of a fragility fracture on or after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and 2. Aged 75 or over with a record of a fragility fracture on or after 1 April 2014 and a diagnosis of osteoporosis. 	3	N/A

OST – rationale for inclusion of indicator set

- Osteoporotic fragility fractures can cause substantial pain and severe disability, are associated with decreased life expectancy and are expected to increase over the next 15 years¹¹⁵. Osteoporotic fragility fractures occur most commonly in the spine (vertebrae), hip (proximal femur) and wrist (distal radius). They also occur in the arm (humerus), pelvis, ribs and other bones. Fractures of the hands and feet (for example metacarpal and metatarsal fractures) are not generally regarded as osteoporotic fragility fractures.
- Interventions for secondary prevention of fractures in patients who have had an osteoporotic fragility fracture include pharmacological intervention.

OST004 (NICE 2011 menu ID: NM29) – For the financial year 2024/25, this indicator is being income protected. The details of how this is applied are in section 2.1 of this document.

OST004 Rationale

- Fragility fractures are fractures that result from low-level trauma, which means mechanical forces that would not ordinarily cause fracture. The WHO has

¹¹⁵ International Osteoporosis Foundation (2020) *SCOPE 2021: a new scorecard for osteoporosis in Europe*. https://www.osteoporosis.foundation/sites/iofbonehealth/files/2021-06/Kanis2021_Article_SCOPE2021ANewScorecardForOsteo.pdf

described this as a force equivalent to a fall from a standing height or less. Reduced bone density is a major risk factor for fragility fractures^{116, 117}.

- ii. Osteoporosis is a disease characterised by low bone mass and structural deterioration of bone tissue. The WHO defines osteoporosis as a bone mineral density of 2.5 or more standard deviations below that of a normal young adult (T-score of -2.5 or less) measured by a central dual-energy X-ray absorptiometry (DXA) scan. Bone mineral density is the major criterion used to diagnose and monitor osteoporosis.
- iii. NICE guidance on osteoporosis fragility fractures recommends that a diagnosis of osteoporosis may be assumed in women aged 75 or over with a fragility fracture if the responsible clinician considers a DXA scan to be clinically inappropriate or unfeasible¹¹⁸. The SIGN guideline on the management of osteoporosis¹¹⁹ recommends that in frail elderly women (aged 80 or over) a DXA scan would be a prerequisite to establish that bone mass density (BMD) is sufficiently low before starting treatment with bone-sparing agents (bisphosphonates), unless the patient has suffered multiple vertebral fractures.
- iv. Osteoporotic fragility fractures can cause substantial pain and severe disability and are associated with decreased life expectancy. Osteoporotic fragility fractures occur most commonly in the spine (vertebrae), hip (proximal femur) and wrist (distal radius). They also occur in the arm (humerus), pelvis, ribs and other bones. Fractures of the hands and feet (for example, metacarpal and metatarsal fractures) are not generally regarded as osteoporotic fragility fractures.
- v. In women, the prevalence of osteoporosis increases markedly with age after menopause¹²⁰, from approximately two per cent at 50 years, rising to more than 25 per cent at 80 years. The NICE cost impact report for technology appraisal TA161 uses a prevalence of 11 per cent of post-menopausal women aged 50 or over with osteoporosis and a clinically apparent osteoporotic fragility fracture, rising to 19 per cent for ages 65 or over. There

¹¹⁶ WHO. Guidelines for preclinical evaluation and clinical trials in osteoporosis. 1998.

¹¹⁷ NICE CG146 (2012, updated 2017) Osteoporosis: assessing the risk of fragility fracture. <http://www.nice.org.uk/guidance/CG146>

¹¹⁸ NICE TA161 (2008, updated 2018). Raloxifene and teriparatide for the secondary prevention of osteoporotic fragility fractures in postmenopausal women. <http://www.nice.org.uk/guidance/TA161>

¹¹⁹ SIGN guideline 142. Management of osteoporosis and the prevention of fragility fractures. 2015. <http://sign.ac.uk/pdf/SIGN142.pdf>

¹²⁰ [1] ScienceDirect (2016) Epidemiology of fractures in the United Kingdom 1988–2012: Variation with age, sex, geography, ethnicity and socioeconomic status. <http://dx.doi.org/10.1016/j.bone.2016.03.006>

are an estimated 180,000 new fragility fractures in postmenopausal women in the UK each year; three quarters in women aged 65 or over.

- vi. Postmenopausal women with an initial fracture are at substantially greater risk of subsequent fractures. Half of patients with a hip fracture have previously had a fragility fracture of another bone.
- vii. Hip fractures are associated with increased mortality; estimates of the relative mortality risk vary from two to greater than ten in the 12 months following hip fracture. However, it is unclear to what extent this can be attributed to fracture alone, as opposed to pre-existing co-morbidity.
- viii. The SIGN guideline recommends that patients who have suffered one or more fragility fractures are priority targets for investigation and treatment of osteoporosis.
- ix. This indicator promotes structured case finding for osteoporosis in patients who have had a fragility fracture. Its aim is to promote the secondary prevention of fragility fracture in patients with osteoporosis.

OST004 Reporting and verification

- i. The business rules for the two-part register will look for the following criteria:
 - a) In patients aged 50 or over and who have not attained the age of 75:
 - the earliest DXA scan with a positive result of osteoporosis
 - the earliest diagnosis of osteoporosis
 - a fragility fracture at any point on or after the implementation date (1 April 2012)
 - b) In patients aged 75 or over:
 - the earliest diagnosis of osteoporosis
 - a fragility fracture at any point on or after the implementation date (1 April 2014)
- ii. Patients aged 50 or over and under the age of 75 in whom a diagnosis of osteoporosis has not been confirmed with DXA scanning will not be included in the register.
- iii. For patients aged 75 or over the diagnosis of osteoporosis can be either confirmed with DXA scanning or clinically assumed (if DXA scan is considered to be clinically inappropriate or unfeasible).

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- iv. Patients with fragility fractures sustained in the last three months of the year will be excepted from this indicator.
 - v. Although this indicator defines two separate registers, the disease register for calculating the APDF is defined as the sum of the number of patients on both registers.

3.19 Rheumatoid arthritis (RA)

Indicator	Points	Thresholds
Records		
RA001. The contractor establishes and maintains a register of patients aged 16 or over with rheumatoid arthritis	1	N/A

RA – rationale for inclusion of indicator set

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- i. Rheumatoid arthritis (RA) is a chronic, disabling auto-immune disease characterised by inflammation in the peripheral joints, which, when not controlled, causes swelling, stiffness, pain and progressive joint destruction. For a small proportion of people with RA, inflammatory disease outside the joints (i.e. eye and lung disease, vasculitis) can pose a significant problem. RA affects around one per cent of the population; of these people, approximately 15 per cent have severe RA.
 - ii. Although the confirmation of diagnosis and initiation of treatment may take place in secondary care, primary care has an important role to play in the management of RA. This may include checking cardiovascular risk and blood pressure, checking the person's risk for osteoporosis and assessing for signs of low mood or depression. An annual face-to-face review in primary care is an opportunity to assess the effect of the disease upon the person's life, for example side effects to medication and whether they would benefit from any referrals to the MDT.

RA001 (NICE 2012 menu ID: NM55) – For the financial year 2024/25, this indicator is being income protected. The details of how this is applied are in section 2.1 of this document.

RA001 Rationale

- i. The RA register includes patients aged 16 or over with established and recent-onset disease and in whom there is a definite diagnosis of RA, irrespective of evidence of positive serology and current disease activity status.
- ii. The register is restricted to patients aged 16 or over, to conform to international standards for differentiating RA from juvenile idiopathic arthritis.
- iii. The register also includes patients with inactive RA. There are three potential groups of patients whose disease may be referred to as inactive:
 1. Patients who are being treated and whose disease is in remission.
 2. Patients who are not currently receiving treatment for RA but have evidence of past disease, i.e. joint deformities. These patients are on the register as they remain at risk of the systemic effects of RA.
 3. Patients who are not currently receiving treatment for RA and have no clear evidence of past or current disease. Where the contractor believes the patient may have inactive RA, an anti-CCP antibody test may be beneficial. If a contractor is in doubt about a patient's diagnosis, it is recommended to perform a clinical review based on the original diagnosis

and then remove any inaccurate diagnoses that may be present. Inaccurate diagnoses that are removed from a patient's patient record will also remove them from the register.

- iv. Recognition of synovitis in primary care and prompt referral for specialist advice (within three days) is key to the early identification and treatment of RA. Synovitis is inflammation of the membrane that lines the inside of synovial joints (most of the joints in the body). Symptoms of inflammation include pain, swelling, heat and loss of function of an affected joint.
- v. Identifying recent-onset RA can be challenging in primary care because of the variety of ways in which synovitis can present itself and the small number of patients who have RA compared with the number of patients with musculoskeletal symptoms. NICE guideline NG100¹²¹ recommends that patients with persistent synovitis are referred for specialist opinion. Urgent referral is needed when any of the following are present:
 - 1. The small joints of the hands or feet are affected.
 - 2. More than one joint is affected.
 - 3. There has been a delay of three months or longer between the onset of symptoms and seeking medical advice.
 - 4.
- vi. Early identification of recent-onset RA is important because long-term outcomes are improved if disease modifying anti-rheumatic drugs (DMARDs) treatment is started within three months of the onset of symptoms.

RA001 Reporting and verification

- i. See indicator wording for requirement criteria.
- ii. Verification – Commissioners may wish to discuss with contractors the process they use to identify patients with RA, and the number of patients with inactive disease whose diagnoses have been reviewed and the outcomes of this review.

¹²¹ NICE NG100 (2018, updated 2020) Rheumatoid arthritis in adults.
<https://www.nice.org.uk/guidance/ng100>

3.20 Palliative care (PC)

Indicator	Points	Thresholds
Records		
PC001. The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age	3	N/A

PC – rationale for inclusion of indicator set

Palliative or end of life care is the active, holistic care of patients with advanced, progressive disease and those important to them. By identifying patients early, they can be supported to live and die well through proactive involvement in planning their care and support, along with those important to them, ensuring access to the right services in line with their needs and preferences.

NHS Long Term Plan¹²² makes a clear commitment to improve training and support to staff to enable a more timely identification of palliative and end of life care needs for people of all ages, leading to the offer of a personalised care and support plan. This is further supported by:

- a. [Palliative and end of life care: Statutory guidance for integrated care boards \(ICBs\)](https://www.england.nhs.uk/publication/palliative-and-end-of-life-care-statutory-guidance-for-integrated-care-boards-icbs/) <https://www.england.nhs.uk/publication/palliative-and-end-of-life-care-statutory-guidance-for-integrated-care-boards-icbs/>
- b. The National Palliative and End of Life Care Partnership. Ambitions for palliative and end of life care: A national framework for local action 2021-2026 <https://www.england.nhs.uk/wp-content/uploads/2022/02/ambitions-for-palliative-and-end-of-life-care-2nd-edition.pdf>

Timely identification of people in need of this support will be key to making these quality improvements, including those making the transition from children's to adult's services.

¹²² [NHS England. The NHS Long Term Plan. 2019.](#)

PC001 – For the financial year 2024/25, this indicator is being income protected. The details of how this is applied are in section 2.1 of this document.

PC001 Rationale

- i. About one per cent of the population in the UK die each year (over half a million), with an average of 20 deaths per GP per year. In 2021 in England, nearly half of all deaths (48%) were from cardiovascular, just over a third (34%) from respiratory conditions, over a quarter (29%) from cancer and nearly one fifth (17%) were dementia. It is estimated that three quarters of all deaths may be anticipated. Considerable benefits of identifying these patients include providing the best health and social care to both patients and those important to them, by prioritising them, anticipating need, initiating conversations and enabling patients to express informed preferences about the care and support they need.
- ii. Identifying patients in need of palliative and end of life care, assessing their needs and preferences, offering personalised care and support planning, including advance care planning and proactively working in collaboration with other services/teams, are key to the provision of high-quality palliative and end of life care in general practice. This indicator is focused on identifying these patients – a critical first step in addressing the key elements of good medical practice identified by the General Medical Council.¹²³
- iii. A patient is included on the register if any of the following apply:
 - Their death in the next 12 months can be reasonably predicted (rather than trying to predict, clinicians often find it easier to ask the 'surprise question' – 'Would I be surprised if this patient were still alive in 12 months?').
 - They have advanced or irreversible disease and clinical indicators of progressive deterioration and thereby a need for palliative care (e.g. they have one or more core/general and one disease specific indicator in accordance with the gold standard framework (GSF) prognostic indicators guidance or the Supportive and Palliative Care Indicators Tool (SPICT)).

¹²³ General Medical Council. 2010. Treatment and care towards the end of life: good practice in decision making. <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/treatment-and-care-towards-the-end-of-life>

- They are entitled to a **SR1** form to speed up the payment of financial benefits, which can be issued when a patient is considered to be in the **last 12 months of their life.**
- iv. The register applies to all patients fulfilling the criteria regardless of age or diagnosis. The creation of a register will not in itself improve care but **through systematic identification of people approaching the end of life, contractors are able to demonstrate compliance with [NICE Quality Standard for End of Life Care for Adults \(QS13\)](#) and NICE Quality Standard for infants, children and young people (QS160), and can provide opportunities to discuss advance care planning, how to access care and support 24/7 for themselves and their carer(s), aiding the coordination of care between health and social care practitioners within and across different services and organisations.**

PC001 Reporting and verification

See indicator wording for requirement criteria.

There is no prevalence adjustment made to the palliative care indicator. 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.

3.21 Non-diabetic hyperglycaemia (NDH)

Indicator	Points	Thresholds
Records		
NDH002. The percentage of patients with non-diabetic hyperglycaemia who have had an HbA1c or fasting blood glucose performed in the preceding 12 months	18	50–90%

NDH – rationale for inclusion of indicator set

- NDH (**also known as prediabetes**) is defined as an HbA1c of 42-47mmol/mol or a fasting plasma glucose (FPG) of 5.5-6.9mmol/l¹²⁴. There were **more than**

¹²⁴ [Recommendations | Type 2 diabetes: prevention in people at high risk | Guidance | NICE](#)

2.7 million people with NDH in England in March 2022, with around 580,000 people newly diagnosed in 2021/22.

- ii. The NHS has invested significantly in behavioural interventions for those with NDH in order to prevent and delay the onset of type 2 diabetes. The Healthier You: NHS Diabetes Prevention Programme (NHS DPP) is the largest undertaking of its kind in the world and over 700,000 people have participated since its introduction in 2016. An independent evaluation of the programme has demonstrated its effectiveness, with programme completion (defined as attending >60% of sessions) associated with a relative risk reduction of 37% for the development of type 2 diabetes.
- iii. The NHS DPP is available across the whole of England, and GP practices can refer patients aged 18 or over with a blood test result demonstrating NDH in the 12 months prior to referral. Individuals with a history of Gestational Diabetes Mellitus (GDM) are also eligible and have an additional route of accessing the programme through self-referral. Participants of the NHS DPP must not be pregnant, have ever been diagnosed with type 2 diabetes, be recorded as living with moderate/severe frailty, have an active eating disorder or have had bariatric surgery within the previous 2 years.

NDH002 (NICE 2017 menu ID: NM150) – For the financial year 2024/25, this indicator is being income protected. The details of how this is applied are in section 2.1 of this document.

NDH002 Rationale

- i. NICE Guidance (PH38¹²⁵) recommends that everyone with NDH is offered an annual blood test to check for progression to Type 2 diabetes. Despite this, there is wide variation in the monitoring of people with NDH.
- ii. The aim of this indicator is to promote early identification if people progress from having NDH to type 2 diabetes, as early recognition and management of diabetes is associated with improved long-term outcomes. Criteria for diagnosing diabetes are discussed in the diabetes section of this guidance.

NDH002 Reporting and verification

- i. See indicator wording for requirement criteria.
- ii. The register for the purpose of calculating the APDF is defined as all patients aged 18 or over with a record of non-diabetic hyperglycaemia or pre-diabetes,

¹²⁵ NICE PH38 (2012, updated 2017) Type 2 diabetes: prevention in people at high risk
<http://www.nice.org.uk/guidance/ph38>

which has not been superseded by a diagnosis of diabetes recorded prior to the beginning of the financial year.

4. Public health domain

4.1 Blood pressure (BP)

Indicator	Points	Thresholds
BP002. The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years	15	50–90%

BP002 (based on NM61)

BP002 Rationale

- i. Detecting elevated blood pressure and, where indicated, treating it, is known to be an effective health intervention. Raised blood pressure is common if it is measured on a single occasion but with repeated measurement blood pressure tends to drop. NICE guideline recommendations for the diagnosis and treatment of hypertension¹²⁶ are to be followed by practitioners when deciding on whether to treat raised blood pressure.
- ii. The age limit of aged 45 or over has been chosen as the vast majority of patients develop hypertension after this age. The age range 45 or over, coupled with a five-year reference period is in line with the NHS Health Checks Scheme, which starts at 40 years old. It is also to align the indicator more closely with the vascular checks programme and the cost-effectiveness modelling undertaken to support that programme.
- iii. It is anticipated that contractors will opportunistically check blood pressures in all adult patients.

BP002 Reporting and verification

- i. See indicator wording for requirement criteria.
- ii. Generally, personalised care adjustment criteria (see Section 6) do not apply to this indicator. However, practices are able to remove patients from the denominator where the patient declines to accept offered care.

¹²⁶ NICE CG136 (2019, updated 2023) Hypertension in adults.
<http://www.nice.org.uk/guidance/ng136>

4.2 Obesity (OB)

Indicator	Points	Thresholds
Records		
OB003. The contractor establishes and maintains a register of patients aged 18 years or over living with obesity, appropriately adjusted for ethnicity in line with NICE guidelines – either with a BMI greater than or equal to 30 kg/m ² recorded in the preceding 12 months, or a BMI greater than or equal to 27.5 kg/m ² recorded in the preceding 12 months for patients with a South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean family background	8	N/A

OB – rationale for inclusion of indicator set

- i. The Global Burden of Disease study identifies obesity as one of the top five risk factors contributing to premature death in England along with smoking, poor diet, high blood pressure and drug and alcohol use¹²⁷. Nearly two-thirds of adults in England are living with overweight or obesity, some of the worst figures in Europe¹²⁸. As noted in the NHS Long Term Plan obesity is linked with type 2 diabetes, high blood pressure, high cholesterol, increased rates of respiratory, musculoskeletal and liver disease and certain types of cancer.
- ii. The NHS Long Term Plan commits to a targeted offer of support and access to weight management services in primary care for people with a diagnosis of hypertension or type 2 diabetes with a BMI >30, (adjusted appropriately for ethnicity) amongst other actions to reduce obesity.

iii. Further information

- NICE has produced multiple guidelines on clinical and public health approaches to tackling obesity, they can be accessed via the NICE website: <https://www.nice.org.uk/guidance/lifestyle-and-wellbeing/diet--nutrition-and-obesity>

¹²⁷ Steel et al. Changes in health in the countries of the UK and 150 English Local Authority areas 1990-2016: a systematic analysis for the Global Burden of disease Study 2016. The Lancet 2018;392(10158):1647-1661. [https://doi.org/10.1016/S0140-6736\(18\)32207-4](https://doi.org/10.1016/S0140-6736(18)32207-4)

¹²⁸ OECD. Obesity update 2017. Available from <http://www.oecd.org/health/obesity-update.htm>

OB003 – For the financial year 2024/25, this indicator is being income protected. The details of how this is applied are in section 2.1 of this document.

OB003 Rationale

- i. The register includes all patients whose BMI has been recorded by the practice as part of routine care. It is expected that this data will inform public health planning and support onward referral to weight management services.
- ii. NICE guideline CG189¹²⁹ recommends using BMI as a practical estimate of adiposity in adults. Identifying people with a BMI ≥ 25 includes a preventative aspect of care in managing obesity and supports interventions for people at risk of obesity (i.e. those who are overweight but not yet obese). People with a South Asian, Chinese, other Asian, Middle Eastern, Black, African or African-Caribbean family background are prone to central adiposity and their cardiometabolic risk occurs at lower body mass index (BMI). NICE guidance therefore, recommends a differential BMI threshold for identification of obesity in relation to these patient groups. The wording of this indicator was updated accordingly for 2023/24.

OB003 Reporting and verification

- i. See indicator wording for requirement criteria.

¹²⁹ NICE CG189 (2014, updated 2023) Obesity. <https://www.nice.org.uk/guidance/cg189>

4.3 Smoking (SMOK)

Indicator	Points	Thresholds
Records		
SMOK002. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months	25	50–90%
Ongoing management		
SMOK004. The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 24 months	12	40–90%
SMOK005. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 months	25	56–96%

SMOK – rationale for inclusion of indicator set

- i. Smoking has been identified as the top modifiable risk factor for neurological diseases and premature death in England¹³⁰. In England, 8.8% of pregnant women were known to be smokers at the time of delivery¹³¹. Smoking is linked to a wide range of disease and conditions including cancers, respiratory disease, cardiovascular disease, stomach and duodenal ulcers, erectile dysfunction and infertility, osteoporosis, cataracts, age related macular

¹³⁰ [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(21\)01169-7/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)01169-7/fulltext)

¹³¹ NHS Digital. Statistics on Women's Smoking Status at Time of Delivery: England Quarter 2, 2020-21: Statistics on Women's Smoking Status at Time of Delivery: England, Quarter 4, 2022-23 - NHS Digital

degeneration and periodontitis¹³². Smoking during pregnancy can cause serious pregnancy related health problems, these include: complications during labour and an increased risk of miscarriage, premature birth, still birth, low birth-weight and sudden unexpected death in infancy¹³³. Smoking during pregnancy also increases the risk of infant mortality by an estimated 40 %¹³⁴ and has a detrimental impact on infancy through to childhood¹³⁵.

- ii. The aim of this domain is to increase the proportion of successful smoking quit attempts by providing the best available treatment. There is good evidence to suggest that offering support and treatment is sufficient to motivate some smokers to attempt to stop who would not have done so with brief advice to quit alone.
- iii. 'An offer of treatment' means offering a referral to a local Stop Smoking Service adviser (who might be a member of the practice team) plus pharmacotherapy. Where such treatment is not acceptable to the patient, an alternative form of brief support, such as follow-up appointments with a GP or practice nurse trained in smoking cessation, may be offered.
- iv. The NICE guidance on tobacco¹³⁶ identifies the evidence-based interventions for adults who smoke:
 - behavioural support (individual and group)
 - very brief advice
 - bupropion¹³⁷
 - nicotine replacement therapy (NRT) – short and long acting
 - varenicline¹³⁸
 - nicotine-containing e-cigarettes

¹³² Hiding in plain sight: Treating tobacco dependency in the NHS | RCP London, RCP Hiding in Plain Sight Report, 2018.

¹³³ Hiding in plain sight: Treating tobacco dependency in the NHS | RCP London, RCP Hiding in Plain Sight Report, 2018.

¹³⁴ DH. Review of the health inequalities infant mortality PSA target. 2007.

<http://www.perinatal.nhs.uk/smoking/Health%20Inequalities%20report%202007.pdf>

¹³⁵ Passive smoking prelims, Tobacco Advisory Group of the Royal College of Physicians, March 2010

¹³⁶ NICE NG209 (2021, updated 2023) Tobacco: preventing uptake, promoting quitting and treating dependence. <https://www.nice.org.uk/guidance/ng209>

¹³⁷ See information on [bupropion hydrochloride](#) in the British national formulary.

¹³⁸ See information on [varenicline](#) in the British national formulary.

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- v. For people who smoke and who are using, or are interested in using, a nicotine-containing **electronic cigarette** (e-cigarette **or vape**) on general sale to quit smoking, NICE recommend you explain that:
- although these products are not licensed medicines, they are regulated by the Tobacco and Related Products Regulations 2016
 - there is not enough evidence to know whether there are long-term harms from e-cigarette use
 - use of e-cigarettes is likely to be substantially less harmful than smoking
 - any smoking is harmful, so people using e cigarettes should stop smoking tobacco completely
- vii. Due to the potential for ex-smokers to resume smoking within three years of cessation, it is good clinical practice to ask patients with a history of smoking their current smoking status and offer treatment and advice where necessary. It is also good practice to ask and record the smoking status of newly registered patients and to offer support and treatment where necessary.

SMOK002 (NICE menu 2011 ID: NM38)

SMOK002 Rationale

- i. See rationale above.

SMOK002 Reporting and verification

- i. See indicator wording for requirement criteria. The contractor should report smoking status using the following guidance:

1. Smokers

- i. For patients who smoke, smoking status should be recorded in the preceding 12 months.

2. Non-smokers

- i. It is recognised that life-long non-smokers are very unlikely to start smoking and repeatedly asking smoking status can be unnecessary. Smoking status for this group of patients should be recorded in the

preceding 12 months until the end of the financial year in which the patient reaches the age of 25.

- ii. Once a patient is over the age of 25 years (e.g. in the financial year in which they reach the age of 26 or in any year following that financial year) to be classified as a non-smoker they should be recorded as:
 - Never smoked which is both after their 25th birthday and after the earliest diagnosis date for the disease which led to the patient's inclusion on the SMOK002 register (e.g. one of the conditions listed on the SMOK002 register).

3. Ex-smokers

- i. Ex-smokers can be recorded as such in the preceding 12 months for SMOK002. Practices may choose to record ex-smoking status on an annual basis for three consecutive financial years and after that smoking status need only be recorded if there is a change. This is to recognise that once a patient has been an ex-smoker for more than three years they are unlikely to restart.
- ii. For the purposes of QOF, users of electronic cigarettes who have never smoked or given up smoking should be classified as non-smokers or ex-smokers respectively.
- iii. The disease register for the purpose of calculating APDF for SMOK002 and SMOK005 is defined as the sum of the number of patients on the disease registers for each of the conditions listed in the indicator wording. Patients with one or more co-morbidities (e.g. diabetes and CHD) are only counted once.

SMOK004 (based on NM40)

SMOK004 Rationale

- i. See rationale above.

SMOK004 Reporting and verification

- i. See indicator wording for requirement criteria.
- ii. There is no APDF calculation for SMOK004.

SMOK005 (NICE 2011 menu ID: NM39) – For the financial year 2024/25, this indicator is being income protected. The details of how this is applied are in section 2.1 of this document.

SMOK005 Rationale

- i. See rationale above for guidance on 'support and treatment' and smoking cessation.
- ii. This indicator relates to patients who are on the disease registers for CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma and mental health who are recorded as current smokers.

SMOK005 Reporting and verification

- i. See indicator wording for requirement criteria.
- ii. The disease register for the purpose of calculating APDF for SMOK002 and SMOK005 is defined as the sum of the number of patients on the disease registers for each of the conditions listed in the indicator wording. Patients with one or more co-morbidities (e.g. diabetes and CHD) are only counted once.

4.4 Vaccination and immunisations (VI)

Indicator	Points	Thresholds

VI001. The percentage of babies who reached 8 months old in the preceding 12 months, who have received at least 3 doses of a diphtheria, tetanus and pertussis containing vaccine before the age of 8 months	18	89-96%
VI002. The percentage of children who reached 18 months old in the preceding 12 months, who have received at least 1 dose of MMR between the ages of 12 and 18 months	18	86-96%
VI003. The percentage of children who reached 5 years old in the preceding 12 months, who have received a reinforcing dose of DTaP/IPV and at least 2 doses of MMR between the ages of 1 and 5 years	18	81-96%
VI004. The percentage of patients who reached 80 years old in the preceding 12 months, who have received a shingles vaccine between the ages of 70 and 79 years	10	50-60%

VI – rationale for inclusion of indicator set

- i. Vaccination currently prevents 2-3 million deaths worldwide every year ¹³⁹. Recently, the World Health Organization (WHO) listed vaccine hesitancy as one of their top 10 biggest threats to global health. Health workers, especially those in communities, remain the most trusted advisors and influencers of vaccination decisions and play a key role in providing patients with trusted, credible information on vaccines¹⁴⁰.

Note on vaccinations delivered overseas

- i. Where a patient has been vaccinated overseas in accordance with the UK National Vaccination Schedule (i.e. the schedule of the overseas country conforms to the UK schedule) practices can record delivery of the vaccination in their clinical system to ensure that the vaccination counts towards QOF achievement. For avoidance of doubt, if a patient has been vaccinated overseas in accordance with the UK national schedule and appropriate evidence has been provided of this vaccination event, the patient should count as a success in respect of any relevant QOF indicator – it should not simply trigger a Personalised Care Adjustment.

¹³⁹ <https://www.who.int/en/news-room/fact-sheets/detail/immunization-coverage>

¹⁴⁰ <https://www.who.int/news-room/spotlight/ten-threats-to-global-health-in-2019>

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- ii. When a patient or their representative reports that a vaccination has been delivered overseas or in another setting, individual clinicians should exercise their judgement to determine that a vaccination has been delivered and to record it in the patient record. The Green Book [states](#), “If children and adults coming to the UK do not have a documented or reliable verbal history of immunisation, they should be assumed to be unimmunised and a full course of required immunisations should be planned.” Patients arriving from overseas with a “documented or reliable verbal history of immunisation” can be assumed to be immunised and recorded as such in the GP patient record – though in the case of reliable verbal histories, it may not be possible to record the batch number or exact vaccination date.
 - iii. Where a patient has been vaccinated overseas in accordance with the UK national schedule, the practice can ensure that the vaccination counts towards QOF achievement but does not attract an item of service payment by coding the vaccination event in the following way:
 1. Backdate the event date of the vaccination SNOMED code to accurately reflect when the vaccination was delivered.
 2. Set the GMS flag to ‘No’ (for EMIS and Cegedim practices) or the ‘Event done’ flag to ‘No’ (for TPP practices).¹⁴¹
 3. If the vaccination is for MMR or Shingles, use the “MMR vaccination given by other healthcare provider” or “Shingles vaccination given by other healthcare provider” SNOMED code.¹⁴²
 4. Add free text associated with the vaccination SNOMED code to note the date the vaccine was given and where.

Note on automated Personalised Care Adjustment (PCA) introduced in 2023/24

- i. As part of the changes to the GP Contract 2023/24 published on 6 March 2023, a new PCA was introduced for VI001, VI002 and VI003 to take into account patients who registered at the practice too late (either too late in age, or too late in the financial year) to be vaccinated in accordance with the UK

¹⁴¹ The purpose of the GMS flag is to denote when an activity was delivered in fulfilment of the practice’s GMS (inclusive of PMS and APMS) contract (GMS=True), or either delivered by the practice outside the GMS contract or delivered by another healthcare provider (GMS=False). TPP has not implemented a GMS flag, but offers analogous functionality in the form of an ‘Event done’ flag which, if set to false, denotes that the practice did not deliver the activity.

¹⁴² ‘Vaccination given by other healthcare provider’ SNOMED codes exist for a limited number of vaccines. MMR and Shingles are the only vaccinations in QOF with a ‘vaccination given by other healthcare provider’ code available.

national schedule (or, where they differ, the requirements of the relevant QOF indicator).

- ii. From April 2023, this new automated PCA has been built into the business rule logic underpinning the QOF V&I GPES extracts and applies in circumstances where a child is registered with a practice and:
 1. there is insufficient time to provide any incomplete vaccinations either within the required timeframes to meet the indicator requirements, or
 2. where a child has an incomplete vaccination status and is now older than the cut-off age required by the indicator.
- iii. The PCA cannot be applied manually and will be automatically applied by the indicator logic. The PCA will be superseded in the extract logic by success (i.e. the relevant vaccinations being given before the relevant cut-off age required by the indicators). The PCA applies once the individuals are registered with the practice and the relevant logic parameters are met. Where the PCA is applied, it will remove the child from both the denominator and numerator thus not impacting on achievement of the relevant indicator.
- iv. In the event a child is registered with a practice and has already reached the relevant indicator's cut off age - where the cut off age is 8 months for VI001, 18 months for VI002 and 5 years for VI003 - and had incomplete vaccinations, then the automatic PCA will be applied. This is because it is by no fault of the practice that this child was not vaccinated.
- v. However, for a child that is registered with a practice at an age younger than the cut off age for the relevant indicator, then the PCA is flexibly applied depending on both the time remaining prior to the child reaching the cut off age and the number of outstanding doses. A timeframe of 31 days per outstanding dose from registration date to meeting the cut off age for the indicator is applied. Further information can be found in the [business rules](#).
- vi. Practices may want to check whether this PCA is active on the system by using the various system reporting tools such as 'How am I driving?' before the end of the financial year.
- vii. Some examples of how the new PCA applies to the three V&I indicators are provided below:

For VI001.

- i. If a child is registered with a practice on or after 7 months of age and has two or fewer doses of diphtheria, tetanus and pertussis containing vaccine prior to

registering then the PCA would automatically be applied as there would be insufficient time to offer and administer the required doses.

- ii. If a child is registered with a practice on or after 6 months of age and has one or no doses of diphtheria, tetanus and pertussis containing vaccine prior to registering then the PCA would automatically be applied as there would be insufficient time. However, if a child registered with the practice at 6 months of age and had already had two doses of diphtheria, tetanus and pertussis containing vaccine prior to registering and the third dose was not given by the practice before the child turns 8 months, then the practice would not achieve the indicator for this specific child – this is because the practice would have had sufficient time to give the remaining dose.
- iii. If a child registered with a practice on or after 5 months of age and had no doses of diphtheria, tetanus and pertussis containing vaccine prior to registering then the PCA would automatically be applied as there would be insufficient time. However, if a child registered with the practice at 5 months of age and had already had one or two doses of diphtheria, tetanus and pertussis containing vaccine prior to registering and the third dose was, or second and third doses were, not given by the practice before the child turns 8 months, then the practice would not achieve the indicator for this specific child – this is because the practice would have had sufficient time to give the remaining one or two dose(s).
- iv. If a child registered with a practice between 1-4 months of age and had no doses of diphtheria, tetanus and pertussis containing vaccine prior to registering and the practice does not give all three doses before the child turns 8 months old, then the practice would not achieve the indicator for this specific child. The automated PCA would not apply.

For VI002.

- i. If a child has reached 17 or 18 months of age when registering with the practice and had not had an MMR vaccination, then the automatic PCA will be applied. However, if the child is 16 months or younger and does not receive one dose of MMR vaccination before they turn 18 months, then the practice would not achieve this indicator for the specific child.

For VI003.

- i. If a child registered with a practice on or after 4 years and 11 months of age and had either (1) two MMR vaccinations but no booster DTap/IPV or (2) only

one MMR and the booster DTap/IPV, then the automatic PCA will be applied as there is insufficient time.

- ii. If a child registered with a practice on or after 4 years and 10 months of age and had either (1) only had one MMR and no booster DTap/IPV or (2) no MMR but had the booster DTap/IPV, then the automatic PCA will be applied as there is insufficient time.
- iii. If a child registered with a practice on or after 4 years and 9 months of age and had no MMR vaccinations and no booster DTap/IPV, then the automatic PCA will be applied as there is insufficient time.
- iv. If a child registered with a practice younger than 4 years and 9 months of age and does not receive both MMR vaccinations and the booster DTap/IPV then the practice would not achieve the indicator for this specific child.

VI001 (NICE 2020 menu ID: NM197)

VI001 Rationale

- i. Diphtheria, tetanus and pertussis (whooping cough) are acute infectious diseases that can have severe complications. The routine immunisation schedule states that the hexavalent (6-in-1) vaccine is due at 8, 12 and 16 weeks old for immunisation to diphtheria, tetanus and pertussis (DTaP) as well as poliomyelitis (IPV), haemophilus influenzae type B (Hib) and hepatitis B (Public Health England 2020).
- ii. The indicator supports early vaccination according to the routine immunisation schedule. Measurement by 8 months old allows for vaccination deferral due to febrile illness but aims to achieve immunisation against the named acute infectious diseases as early as possible.
- iii. The lower threshold for this indicator has been lowered to 86% and the upper threshold has been raised to 96% to extend the payment thresholds for this indicator.

VI001 Reporting and verification

- i. See indicator wording for requirement criteria.
- ii. The only personalised care adjustment applicable is where the intervention described in the indicator is contraindicated for the patient.

VI002 (NICE 2020 menu ID: NM198)

VI002 Rationale

- i. MMR is the combined vaccine that protects against measles, mumps and rubella. These are highly infectious conditions that can have serious complications such as meningitis and encephalitis. The first MMR vaccine (MMR1) is due as part of the routine vaccination schedule for England within a month of the child's first birthday ([Public Health England](#) 2020).
- ii. The indicator supports early vaccination with the first dose of the MMR vaccine according to the routine immunisation schedule. Measurement by 18 months old allows for vaccination deferral due to febrile illness but aims to achieve vaccination as early as possible.
- iii. The lower threshold for this indicator has been lowered to 86% and the upper threshold has been raised to 96% to extend the payment thresholds for this indicator.

VI002 Reporting and verification

- i. See indicator wording for requirement criteria.
- ii. The only personalised care adjustment applicable is where the intervention described in the indicator is contraindicated for the patient.

VI003 (NICE 2020 menu ID: NM199)

VI003 Rationale

- i. The indicator supports immunisation according to the routine immunisation schedule. Measurement by 5 years old aims to achieve full immunisation against these infectious diseases before children start school.
- ii. The lower threshold for this indicator has been lowered to 81% and the upper threshold has been raised to 96% to extend the payment thresholds for this indicator.

VI003 Reporting and verification

- i. See indicator wording for requirement criteria.
- ii. The only personalised care adjustment applicable is where the intervention described in the indicator is contraindicated for the patient.

VI004 (based on NM201)

VI004 Rationale

- i. Shingles is caused by the reactivation of a latent varicella zoster virus infection. Incidence and severity of disease are associated with increasing age. The routine immunisation schedule states that the shingles vaccine is due at 70 years old ([Public Health England](#) 2020). Patients remain eligible for the vaccination until their 80th birthday.
- ii. The indicator supports vaccination against shingles for patients 70 years old and over. The effectiveness of the shingles vaccine decreases with increasing age so earlier vaccination is encouraged to ensure optimal protection against shingles.

VI004 Reporting and verification

- i. See indicator wording for requirement criteria. Patients should have received a complete course to be included in the numerator for this indicator. Practices may use a personalised care adjustment if the vaccine is contraindicated or if the patient has declined vaccination.

Public health domain – additional services

For contractors providing additional services the following indicators apply.

4.5 Cervical screening (CS)

Indicator	Points	Thresholds
CS005. The proportion of women eligible for screening aged 25-49 years at end of period reported whose notes record that an adequate cervical screening test has been performed in the previous 3 years and 6 months	7	45-80%
CS006. The proportion of women eligible for screening and aged 50-64 years at end of period reported whose notes record that an adequate cervical screening test has been performed in the previous 5 years and 6 months	4	45-80%

CS indicator 005 (NICE 2017 menu ID: NM154)

CS indicator 006 (NICE 2017 menu ID: NM155)

CS005 and CS006 Rationale

- ii. These indicators are designed to encourage and incentivise contractors to offer age-appropriate cervical screening in line with the recommendations of the NHS **Cervical** Screening Programme and to continue to achieve high levels of uptake of this.
- iii. Specific requirements apply to these indicators in relation to the Personalised Care Adjustment. These are detailed in Section 6.

CS005 and CS006 Reporting and verification

- i. See indicator wording for requirement criteria.
- ii. Commissioners may require that the contractor can provide a computer print-out showing the number of eligible women on the contractor list, the number with a personalised care adjustment and the number who have had a cervical screening test performed at the appropriate time interval.
- iii. Women **and people with a cervix** need to be sent a minimum of three invitations before the personalised care adjustment of not responding to invitations for care can be applied as described in Section 6 of this guidance. **The first two invitations are sent by the national call/recall service. The third should be sent by the GP practice.** There is a discrete SNOMED code to

record that women have not responded to three invitations for cervical screening.

5. Quality improvement domain

- i. For the financial year 2024/25 the Quality Improvement module (a total of 74 points) that previously focused on workforce and wellbeing and optimising demand and capacity in general practice in 2023/24 is being income protected, the details of how this is applied are in section 2.1 of this document.
- ii. NHS England encourages contractors to recognise areas of care which require improvement and take the appropriate steps to address them, through the development and implementation of quality improvement plans as well as professional discussions within their networks. For the financial year 2024/25 however, NHS England will not be requiring formal submission of plans nor evidence of professional network meetings that have taken place. NHS England continues to highlight the importance of quality improvement with primary care as recognised in the Shared View of Quality¹⁴³

¹⁴³ <https://www.england.nhs.uk/wp-content/uploads/2016/12/nqb-shared-commitment-frmrk.pdf>

6. Personalised care adjustments

- i. Since April 2019, exception reporting is being replaced with a Personalised Care Adjustment (PCA). This allows practices to differentiate between the following reasons for adjusting care and removing a patient from the indicator denominator:
 1. Unsuitability for the patient (e.g. because of medicine intolerance or allergy or contra-indicated polypharmacy).
 2. Patient choice, following a shared decision making conversation.
 3. The patient did not respond to offers of care – recording of this will change to capture actual invitations sent to patients.
 4. The specific service is not available (in relation to a limited number of indicators only).
 5. Newly diagnosed or newly registered patients, as per existing rules.
- ii. As with exception reporting applying a PCA to the patient record will remove that patient from an indicator denominator if the QOF defined intervention has not been delivered. It will not result in patients being removed from the disease register or other target population.
- iii. This mechanism differs from 'exclusions' which refer to patients on a particular clinical register who are not included in an indicator denominator for definitional reasons. For example, an indicator (and therefore the denominator) may refer only to patients of a specific age group, patients with a specific status (e.g. those who smoke), or patients with a specific length of diagnosis, within the register for that clinical area.

Principles

- i. When considering whether a PCA applies to an individual patient, practices are reminded that:
 1. The duty of care remains for all patients.
 2. The decision to apply a personalised care adjustment should be based on clinical judgement, informed by patient preferences and underpinned by shared decision-making principles, with clear and auditable reasons coded or entered in free text on the patient record.

-
3. There should be no blanket personalised care adjustments: the relevant issues with each patient should be considered by the clinician at each level of the clinical indicator set and this decision should be reviewed on a regular basis.
 4. In each case where a personalised care adjustment is applied, in addition to what needs to be reported for payment purposes (in accordance with the business rules), the contractor should also ensure that the reason for the adjustment is fully recorded in a way that can facilitate both safe and effective patient care and audit of the patient record. For example, where a patient has not tolerated medication, the nature of the contraindication should be recorded in the patient's record as well as a code to indicate intolerance.

Criteria for the personalised care adjustment

- i. Personalisation of care can occur for the following reasons which are listed in the order in which they will be extracted in the business rules:
 1. The investigative service or secondary care service is unavailable (where relevant to the indicator).
 2. Intervention described in the indicator is clinically unsuitable.
 3. The patient has chosen not to receive the intervention described in the indicator.
 4. The patient has not responded to invitations for the intervention described in the indicator (a minimum of two invitations for the intervention in the preceding 12 months, except for the cervical screening indicators, where women should receive a total of three invitations for screening).
 5. The patient has registered with the practice or has been newly diagnosed with the condition of interest in the preceding 3 months and has not received the defined clinical measurements (e.g. blood pressure measurement).
 6. The patient has registered with the practice or has been newly diagnosed with the condition of interest in the preceding 9 months and has not achieved the defined clinical standards (e.g. blood pressure control within target levels).
- ii. The PCAs used for each indicator are detailed in the business rules.

- iii. It is recognised that patients may meet more than one of these criteria and in these circumstances all reasons for personalisation should be recorded in the patient's record to facilitate safe and effective patient care. However, as a patient can only be acknowledged as having a personalised care adjustment once within the business rules for a given indicator, they will be allocated to the first criterion they meet in the hierarchy listed above. For example, where a patient is recorded as having registered with the practice in the preceding 3 months and has also chosen not to receive the intervention described in the indicator they would be identified in the business rules as having chosen not to receive the care.
- iv. The hierarchy listed above seeks to priorities clinical judgement and patient choice over other criteria. Applying this hierarchy consistently in the business rules in conjunction with the recording changes described below will support better attribution of the reason for care being personalised, allowing for more meaningful conversations between clinicians, commissioners and regulators.

Interpretation and recording of the personalised care adjustment

- i. The interpretation of these categories and how they should be recorded is detailed further below.

The investigative service or secondary care service is unavailable

- i. This care adjustment will apply only to the following indicators: AST011, COPD0014 and DM014.
- ii. Where one of these services is unavailable, this should be recorded using specific codes which state that the service is unavailable. The contractor is expected to explore fully with their ICB if a suitable investigative or secondary service could be commissioned for the patient prior to entering a 'service unavailable' code in the patient record.
- iii. The frequency with which 'service unavailable' codes should be added to the patient record is noted below and may vary between indicators. Some codes may need to be entered annually, whereas others may only need to be entered once in the relevant timeframe stated in the indicator.

Table 2: Frequency of data entry

Indicator ID	Service unavailable may be recorded
AST011	Within 6 months of diagnosis of asthma

COPD014	Required each year the patient becomes eligible for pulmonary rehabilitation
DM014	Within 279 days of diagnosis of diabetes

Intervention described in the indicator is clinically unsuitable

- i. We envisage this being the main reason for personalisation of care, recognising the importance of clinical judgement in determining the applicability of guideline recommendations to individual patients.
- ii. This category encapsulates the historical exception reporting criteria of 1) patients for whom it is not appropriate to review their chronic disease parameters due to particular circumstances (e.g. receiving end of life care), 2) those who are on maximal tolerated doses of medication, 3) those who have an allergy, contraindication or adverse reaction to medication, 4) those who have not tolerated medications and 5) where the patient has a supervening condition which would make treatment of their condition inappropriate.
- iii. This criterion will be supported by both generic 'patient unsuitable' codes which will apply to all indicators in the clinical area except for indicators VI001, VI002 and VI003) and more specific codes which can be attributed to single indicators. Indicators in the Vaccination and Immunisation domain will be supported by specific codes for clinical unsuitability for a vaccination. Over time, more specific codes will be introduced which define the clinical reasons which might make the intervention clinically unsuitable for an individual patient.
- iv. Codes which indicate ongoing and permanent reasons for personalisation of care such as allergies to specified medication may be entered once in the medical record. Other codes will need to be recorded on an annual basis following an individual patient review of the applicability of the intervention described in the indicator.
- v. It is not acceptable to exclude all patients who are under the care of a consultant. Each case needs to be carefully considered and all reasonable efforts made to provide optimal care.
- vi. Even when a patient is under the care of a consultant only, the contractor should ensure it has evidence that all the requirements of the contract have been carried out. If this evidence is not available, the contractor should assume that the action has not been carried out and either fulfil the requirements of the relevant indicator(s) or obtain evidence from secondary

care that the particular test/check has been carried out. Where the secondary care clinician, in agreement with the primary care clinician, has exercised clinical judgement and decided further action or testing is inappropriate, this should be noted in the patient record. A personalised care adjustment may then be applied.

The patient has chosen not to receive the intervention described in the indicator

- i. This criterion requires that there has been a personal contact or a discussion recorded in the patient record which ideally notes the reasons for the intervention being declined. This contact may be face-to-face or through video conferencing or telephone contact between a health professional and the patient.
- ii. This criterion will be supported by both generic 'informed dissent' codes which will apply to all indicators in the clinical area and more specific codes which can be attributed to single indicators. Practices are encouraged to use more specific codes where they are available.
- iii. The decision to decline a QOF intervention should be reviewed with the patient on an annual basis and recorded annually if necessary. The exceptions to this are indicators CS005 and CS006 where the choice not to receive the intervention need only be entered once during the time-period stated in the indicator. However, as noted in the underpinning principles, good practice would be to revisit this decision on a regular basis. Women who choose to withdraw from the cervical screening call/recall will receive no further offers of screening from the central screening service.

The patient has not responded to invitations for the intervention described in the indicator

- i. To be removed from an indicator denominator using this criterion patients must have been sent a minimum of two invitations for QOF care at two unique time points in the QOF year (i.e. 1 April to 31 March) separated by a minimum of seven calendar days. The exceptions to this are indicators CS005 and CS006 where the patient should have been sent a minimum of three invitations at three unique time points during the timeframe stipulated in the indicator. However, care should continue to be offered on an opportunistic basis where appropriate.

General standards and recording requirements for invitations

-
- i. Many different methods of communication are already available to invite patients for QOF care and these are likely to expand with the ongoing development of digital technology. The NHS also has a legal duty to ensure that patients who have a disability, impairment or sensory loss get information that they can access and understand as set out in the Accessible Information Standard.¹⁴⁴ The first step to making an effective invitation for care therefore is that it is made in a manner which is accessible to the patient. Therefore, practices should prospectively and opportunistically record individual patients preferred methods of communication, for example at the time of the next patient contact. Where a preferred contact method is recorded, this would be used to make the first invitation for care. The second invitation may be via any method.
 - ii. All invitations should be personalised to the patient (i.e. use their name and specify what they are being invited for). Where invitations are being sent via letter or email these should also include information for the patient as to why this care is being offered and its importance for their health care.
 - iii. Invitations should be coded at the time they are sent to the patient. For data extraction purposes, there should be a minimum of seven calendar days between each invitation, but practices should use their judgement in determining the optimal spacing between invitations for their practice population. A longer period may be more appropriate. Codes currently exist to indicate the communication method used to make the invitation and that the patients preferred method was used. Both will be acceptable for QOF purposes.
 - iv. Patients should be sent a minimum of two invitations for care within the QOF year (i.e. 1 April – 31 March). If these invitations are correctly coded then they will be identified through the business rules and there will be no need to add additional codes at year-end to indicate that a patient has not responded to these invitations.
 - v. As at present, generic invitations such as messages added to the right-hand side of prescriptions or notices in the waiting room inviting groups of patients to attend clinics or make appointments will not be acceptable.

¹⁴⁴ <https://www.england.nhs.uk/ourwork/accessibleinfo/>

Invitations for cervical screening

- i. As noted above, the requirement for women to be invited on three separate occasions will continue in line with national screening programme requirements.
- ii. Therefore:
 - a) In those areas where the first two invitations are sent via the central screening service, then contractors are responsible for offering the third invitation.
 - b) Where the central screening service sends out only one letter, then contractors are responsible for offering the second and third invitation.
 - c) Where contractors have opted to run their own call/recall system then they are responsible for making all three invitations.
 - d) Where a woman does not respond to these three invitations then contractors will need to code that this has been the case. Each invitation should be recorded in the patient record as evidence of these may be required for assessment and audit purposes.
 - e) Women may choose to withdraw from the national screening programme. This should be undertaken with caution as women who withdraw from cervical screening call/recall will receive no further offers of screening from the central service. Where women actively decline cervical screening, this should be recorded as such.

The patient has registered with the practice or been newly diagnosed with the condition in the last 3 months of the QOF year and has not received defined clinical measurements.

- i. Where a patient newly registers with a practice or is newly diagnosed with a clinical condition in the last three months of the QOF year (1 January – 31 March), this criterion applies automatically unless the contractor has recorded the defined clinical measurements within the timeframe for the indicator. This is because achievement automatically over-rides any PCA.

The patient has registered with the practice or has been newly diagnosed with the condition in the last 9 months of the QOF year and has not achieved defined clinical standards.

- i. Where a patient newly registers with a practice or is newly diagnosed with a clinical condition in the last nine months of the QOF year (1 July – 31 March), this criterion applies automatically unless the contractor has achieved the

defined clinical standards within the timeframe for the indicator. This is because achievement automatically over-rides any PCA.

7. Glossary of acronyms

Abbreviation	Definition
A&E	Accident and Emergency
ABPM	Ambulatory Blood Pressure Monitoring
ACE-Inhibitor or ACE-I	Angiotensin Converting Enzyme Inhibitor
ACR	Albumin Creatinine Ratio
AF	Atrial Fibrillation
APDF	Adjusted Practice Disease Factor
ARB	Angiotensin Receptor Blocker
AST	Asthma
ATS/ERS	American Thoracic Society/European Respiratory Society
BMD	Bone Mass Density
BMI	Body Mass Index
BMA	British Medical Association
BMJ	British Medical Journal
BNF	British National Formulary
BP	Blood Pressure
BTS	British Thoracic Society
CABG	Coronary Artery Bypass Grafting
CAN	Cancer
CAT	COPD Assessment Test

Abbreviation	Definition
CG	Clinical guideline (NICE)
CHD	Coronary Heart Disease
CHADS ₂	Congestive (HF) Hypertension Age (75 or over) Diabetes Stroke
CHA ₂ DS ₂ -VASc	Congestive (HF) Hypertension Age (75 or over) Diabetes Stroke (prior stroke) Vascular Disease (peripheral artery disease) Age (65–74 years) Sex Category (i.e. female)
CKD	Chronic Kidney Disease
CMO	Chief Medical Officer
COPD	Chronic Obstructive Pulmonary Disease
CPA	Care Programme Approach
CQRS	Calculating Quality Reporting Service
CRP	C-Reactive Protein
CS	Cervical Screening
CVD	Cardiovascular Disease
CVD-PP	CVD Primary Prevention
DEM	Dementia
DEP	Depression
DM	Diabetes Mellitus
DMARD	Disease Modifying Anti-Rheumatic Drugs
DXA	Dual-Energy X-ray Absorptiometry
ED	Erectile Dysfunction
eGFR	Estimated Glomerular Filtration Rate

Abbreviation	Definition
EOLC	End of Life Care
EP	Epilepsy
ES	Enhanced Service
ESR	Erythrocyte Sedimentation Rate
FEV ₁	Forced Expiratory Volume in One Second
FVC	Forced Vital Capacity
GFR	Glomerular Filtration Rate
GMC	General Medical Council
GMS	General Medical Services
GOLD	The Global Initiative for Chronic Obstructive Lung Disease
GP	General Practitioner
GPC England	General Practitioners Committee England
GPES	General Practice Extraction Service
GSF	Gold Standards Framework
HbA _{1c}	Glycated Haemoglobin
HBPM	Home Blood Pressure Monitoring
HF	Heart Failure
HYP	Hypertension
IFCC	International Federation of Clinical Chemistry and Laboratory Medicine
INLIQ	Indicators no longer in in QOF
IQ	Intelligence Quotient

Abbreviation	Definition
JCVI	Joint Committee on Vaccination and Immunisation
LD	Learning Disabilities
LDL	Low Density Lipoprotein
LVSD	Left Ventricular Systolic Dysfunction
MDT	Multi-disciplinary team
MH	Mental Health
MI	Myocardial Infarction
mmHg	Millimetres of Mercury
mmol/l	Millimoles per Litre
MRC	Medical Research Council
NCSI	National Cancer Survivorship Initiative
NDH	Non-Diabetic Hyperglycaemia
NG	NICE guideline
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NRT	Nicotine Replacement Therapy
NSF	National Service Framework
OB	Obesity
OGTT	Oral Glucose Tolerance Test
ONS	Office for National Statistics

Abbreviation	Definition
OST	Osteoporosis
PAD	Peripheral Arterial Disease
PC	Palliative Care
PCA	Personalised Care Adjustment
PCRJ	Primary Care Respiratory Journal
PEF	Peak Expiratory Flow
PH	Public health
PPI	Proton pump inhibitor
PVD	Peripheral Vascular Disease
QI	Quality Improvement
QOF	Quality and Outcomes Framework
QS	Quality standard (NICE)
RA	Rheumatoid Arthritis
RCGP	Royal College of General Practitioners
RCP	Royal College of Physicians
RCN	Royal College of Nurses
SFE	Statement of Financial Entitlements
SMOK	Smoking
SPICT	Supportive and Palliative Care Indicators Tool
STIA	Stroke or Transient Ischemic Attack

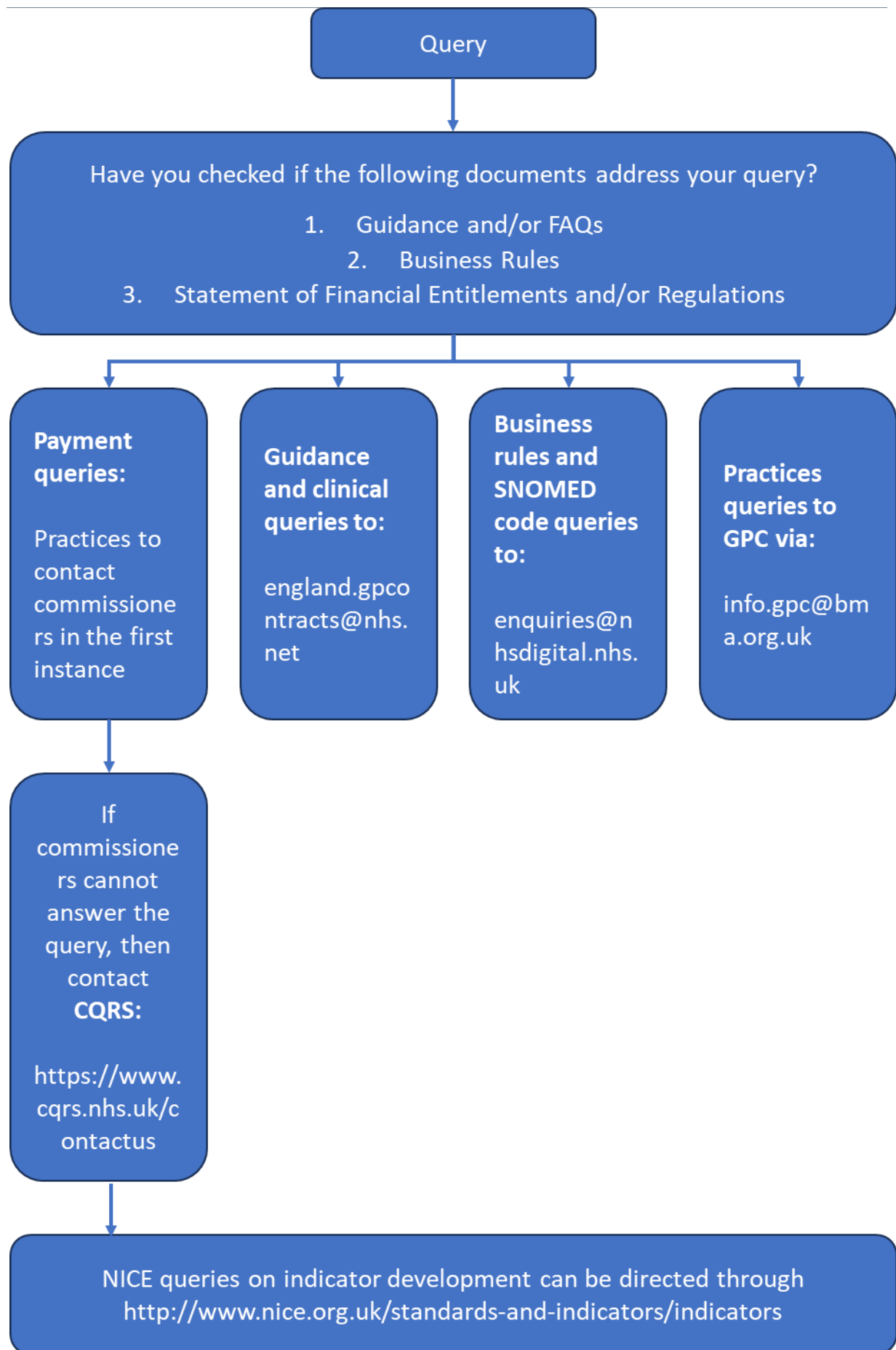
Abbreviation	Definition
TA	Technology appraisal (NICE)
TIA	Transient Ischemic Attack
TSH	Thyroid Stimulating Hormone
UK	United Kingdom
US	United States
WHO	World Health Organisation

8. Queries

Queries fall into three main categories:

- Those which can be resolved by referring to guidance and/or FAQs
- Those requiring interpretation of the guidance or business rules
- Those not anticipated in guidance

Queries may incorporate one or more of the following areas: business rules, coding, payment, CQRS, GPES, and clinical or policy issues. The recipient of the query will liaise with other relevant parties in order to respond and, where necessary, the query will be redirected. **The chart below outlines where questions should be directed to, depending on the subject of the query.**



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This publication can be made available in a number of alternative formats on request.