



Quality and Outcomes Framework guidance for 2021/22

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Section 1: Introduction

Purpose of this document

The aim of this document is to provide additional guidance on the interpretation and verification of the Quality and Outcomes Framework (QOF) indicators for 2021/22 in England, which are listed in Annex D of the Statement of Financial Entitlements Directions (SFE).¹ It is effective from 1 April 2021 and replaces versions issued in previous years.

Changes to the previous version are highlighted in yellow.

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 Adjustment
- Section 7: a full list of indicators which are no longer in QOF but are subject to ongoing data collection
- Section 8: glossary of acronyms
- Section 9: the process for raising queries in relation to QOF indicators and their interpretation
- Section 10: summary of clinical and public health indicator changes for 2021/22

This guidance should be read in conjunction with the SFE Directions and Business Rules.

Definition of 'commissioner'

The NHS Commissioning Board (NHS CB) is the organisation legally responsible for the commissioning of primary care in England, which operates under the name NHS England. NHS England is used throughout this guidance, except where it is necessary to use NHS CB to reflect the SFE Directions. Following the

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

implementation of co-commissioning arrangements references to 'commissioners' in this document could refer to NHS England or a clinical commissioning group (CCG).

Additional indicator information

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

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

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.

Where an indicator has been developed through the NICE led process² it will also be annotated with its 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.**

Identifying the target population or disease register

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

² <https://www.nice.org.uk/media/default/Get-involved/Meetings-In-Public/indicator-advisory-committee/ioc-process-guide.pdf>

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 reminded of this when developing their call/recall systems.

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 then they are eligible for the interventions outlined in all the relevant disease areas.

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.

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.

Quality improvement indicators

Section 5 provides detailed guidance on the interpretation of the quality improvement indicators and the aims and objectives which their quality improvement plans should be seeking to address.

Reporting, payment calculation and verification

Reporting

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 Calculating Quality Reporting Service (CQRS).

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. 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 updated twice yearly around April and October and are available on the NHS Digital website.³

For indicators where achievement is not automatically collected this should be self-declared through the CQRS web-based server. Commissioners may request the evidence underpinning this self-declaration as part of their verification processes.

³ NHS Digital. <http://content.digital.nhs.uk/qofesextractspecs>

Payment calculation and achievement

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.

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

The contractor must ensure that it is able to provide any information that the NHS CB or commissioner 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.

Commissioners and practices will be aware of the requirements of access to patient identifiable data. 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.

Commissioners and practices will be aware of the need to:

- obtain the minimum necessary information for the specific purpose
- anonymise data where possible

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.

The terms 'notes' and 'patient record' are used to indicate either electronic or paper patient records.

Disputes

When a QOF related contractual dispute arises, the commissioner and the 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.

Section 2: Summary of all indicators⁴

Section 2.1: Clinical domain (401 points)

Section 2.1. applies to all contractors participating in QOF.

Atrial fibrillation (AF)

Indicator	Points	Achievement thresholds
Records		
AF001. The contractor establishes and maintains a register of patients with atrial fibrillation	5	
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) (NICE 2014 menu ID: NM81)	12	40-90%
AF007. In those patients with atrial fibrillation with a record of a CHA ₂ DS ₂ -VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (NICE 2014 menu ID: NM82)	12	40-70%

For AF007, patients with a previous score of 2 or above using CHADS₂, recorded prior to 1 April 2015 will be included in the denominator.

Secondary prevention of coronary heart disease (CHD)

Indicator	Points	Achievement thresholds
Records		
CHD001. The contractor establishes and maintains a register of patients with coronary heart disease	4	
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 (NICE 2015 menu ID: NM88)	7	56–96%

⁴ The 'summary of indicators' section is an extract from Annex D of the SFE.

CHD008. 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 (NICE 2013 menu ID: NM68)	12	40-77%
CHD009. 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 (NICE 2019 menu ID: NM191)	5	46-86%

Heart failure (HF)

Indicator	Points	Achievement thresholds
Records		
HF001. The contractor establishes and maintains a register of patients with heart failure	4	
Initial diagnosis		
HF005. The percentage of patients with a diagnosis of heart failure on or after 1 April 2021 which: <ul style="list-style-type: none"> 1. Has been confirmed by an echocardiogram or by specialist assessment between 3 months before or 6 months after entering on to the register; or 2. If newly registered in the preceding 12 months, with no record of the diagnosis originally being confirmed by echocardiogram or specialist assessment, a record of an echocardiogram or a specialist assessment within 6 months of the date of registration <i>(based on NM171)</i>	6	50–90%
Ongoing management		
HF003. In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB (NICE 2019 menu ID: NM172)	6	60–92%
HF006. The percentage of patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, who are currently treated with a beta-blocker licensed for heart failure (NICE 2019 menu ID: NM173)	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 (Based on NM174)	7	50-90%
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Disease registers for heart failure

There are two disease registers used for the HF indicators for the purpose of calculating APDF (practice prevalence):

- a register of patients with HF is used to calculate APDF for HF001, HF005, and HF007,
- a register of patients with HF due to left ventricular systolic dysfunction (LVSD) is used to calculate APDF for HF003 and HF006.

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 as well as for HF.

Hypertension (HYP)

Indicator	Points	Achievement thresholds
Records		
HYP001. The contractor establishes and maintains a register of patients with established hypertension	6	
Ongoing management		
HYP003. 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 (NICE 2012 menu ID: NM53)	14	40-77%
HYP007. The percentage of patients aged 80 years and over with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less (NICE 2012 menu ID: NM54)	5	40-80%

Peripheral arterial disease (PAD)

Indicator	Points	Achievement thresholds
Records		
PAD001. The contractor establishes and maintains a register of patients with peripheral arterial disease (NICE 2011 menu ID: NM32)	2	

Stroke and transient ischaemic attack (STIA)

Indicator	Points	Achievement thresholds
Records		
STIA001. The contractor establishes and maintains a register of patients with stroke or TIA	2	
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 (NICE 2015 menu ID: NM94)	4	57–97%
STIA010. The percentage of patients aged 79 years or under with a history of stroke or TIA in whom the least blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (NICE 2013 menu ID: NM69)	3	40-73%
STIA011. The percentage of patients aged 80 years and over with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less (NICE 2019 menu ID: NM192)	2	46-86%

Diabetes mellitus (DM)

Indicator	Points	Achievement 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 (NICE 2011 menu ID: NM41)	6	
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) (NICE 2015 menu ID: NM95)	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 (NICE 2010 menu ID: NM13)	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 (NICE 2011 menu ID: NM27)	11	40–90%
DM019. 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 140/80 mmHg or less (NICE 2018 menu ID: NM159)	10	38-78%
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 (NICE 2018 menu ID: NM157)	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 (NICE 2018 menu ID: NM158)	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) (NICE 2018 menu ID: NM162)	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 (NICE 2018 menu ID: NM163)	2	50-90%

Asthma (AST)

Indicator	Points	Achievement 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 <i>(based on NM165)</i>	4	
Initial diagnosis		
AST006. The percentage of patients with a diagnosis of asthma on or after 1 April 2021 with either: <ol style="list-style-type: none"> 1. a record of spirometry and one other objective test (FeNO or reversibility or 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 2021 but no record of objective tests being performed at the date of registration, with a record of spirometry and one other objective test (FeNO or reversibility or variability) recorded within 6 months of registration <i>(based on NM166)</i>	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 <i>(based on NM167)</i>	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 <i>(based on NM168)</i>	6	45–80%

Chronic obstructive pulmonary disease (COPD)

Indicator	Points	Achievement thresholds
Records		
<p>COPD009. 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 2021 and 2. Patients with a clinical diagnosis of COPD on or after 1 April 2021 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 in the preceding 12 months 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 2021 who are unable to undertake spirometry <p><i>(based on NM169)</i></p>	8	
Ongoing management		
<p>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 <i>(NICE 2019 menu ID: NM170)</i></p>	9	50–90%
<p>COPD008. 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 an offer of referral to a pulmonary rehabilitation programme (excluding those who have previously attended a pulmonary rehabilitation programme) <i>(NICE 2012 menu ID: NM47)</i></p>	2	40-90%

Dementia (DEM)

Indicator	Points	Achievement thresholds
Records		
<p>DEM001. The contractor establishes and maintains a register of patients diagnosed with dementia</p>	5	

Ongoing management		
DEM004. The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (NICE 2015 menu ID: NM107)	39	35–70%

Depression (DEP)

Indicator	Points	Achievement thresholds
Initial management		
DEP003. 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 (Based on NM50)	10	45–80%

Disease register for depression

There is no register indicator for the depression indicator. The disease register for the depression indicator for the purpose of calculating the APDF is defined as all patients aged 18 or over, diagnosed on or after 1 April 2006, who have an unresolved record of depression in their patient record.

Mental health (MH)

Indicator	Points	Achievement 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	
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 (NICE 2015 menu ID: NM108)	6	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 (based on NM17)	4	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 (based on NM16)	4	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 (based on NM15)	4	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 who 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 (based on NM129)	8	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 (NICE 2015 menu ID: NM130)	8	50-90%

Disease register for mental health

Due to the way repeat prescribing works in general practice, patients on lithium therapy are defined as patients with a prescription of lithium within the preceding six months.

Remission from severe mental illness

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

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

Where a patient is recorded as being 'in remission' they remain on the MH001 register (in case their condition relapses at a later date) but they are excluded from the denominator for indicators MH002, MH003, MH006, MH007, MH011 and MH012.

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

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

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.

Cancer (CAN)

Indicator	Points	Achievement 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	
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 (NICE menu 2020 ID: NM205)	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 been informed of the support available from primary care, within 3 months of diagnosis (based on NM204)	2	70-90%

Chronic kidney disease (CKD)

Indicator	Points	Achievement 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) (NICE 2014 menu ID: NM83)	6	

Epilepsy (EP)

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

Learning disability (LD)

Indicator	Points	Achievement thresholds
Records		
LD004. The contractor establishes and maintains a register of patients with learning disabilities (NICE 2013 menu ID: NM73)	4	

Osteoporosis: secondary prevention of fragility fractures (OST)

Indicator	Points	Achievement 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 (NICE 2011 menu ID: NM29)	3	

Disease register for osteoporosis

Although the register indicator OST004 defines two separate registers, the disease register for the purpose of calculating the APDF is defined as the sum of the number of patients on both registers.

Rheumatoid arthritis (RA)

Indicator	Points	Achievement thresholds
Records		
RA001. The contractor establishes and maintains a register of patients aged 16 or over with rheumatoid arthritis (NICE 2012 menu ID: NM55)	1	
Ongoing management		
RA002. The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 12 months (NICE 2012 menu ID: NM58)	5	40–90%

Palliative care (PC)

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

Disease register for palliative care

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

Non diabetic hyperglycaemia (NDH)

Indicator	Points	Achievement thresholds
Records		
NDH001. The percentage of patients with non-diabetic hyperglycaemia who have had an HbA1c or fasting blood glucose performed in the preceding 12 months (NICE 2017 menu ID: NM150)	18	50–90%

Section 2.2: Public health domain (160 points)

Section 2.2.1: Public health domain

Section 2.2.1. applies to all contractors participating in QOF.

Blood pressure (BP)

Indicator	Points	Achievement thresholds
BP002. The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years <i>(based on NM61)</i>	15	50–90%

Obesity (OB)

Indicator	Points	Achievement thresholds
Records		
OB002. The contractor establishes and maintains a register of patients aged 18 years or over with a BMI ≥ 30 in the preceding 12 months <i>(based on NM143)</i>	8	

Smoking (SMOK)

Indicator	Points	Achievement 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 <i>(NICE 2011 menu ID: NM38)</i>	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 <i>(based on NM40)</i>	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	25	56–96%

who have a record of an offer of support and treatment within the preceding 12 months (NICE 2011 menu ID: NM39)		
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Disease register for smoking

The disease register for the purpose of calculating the 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 indicators. Any patient who has one or more co-morbidities, e.g. diabetes and CHD, is only counted once on the register for SMOK002 and SMOK005.

There is no APDF calculation for SMOK004.

Requirements for recording smoking status

Smokers

For patients who smoke this recording should be made in the preceding 12 months for SMOK002.

Non-smokers

It is recognised that life-long non-smokers are very unlikely to start smoking and indeed find it quite irritating to be asked repeatedly regarding their smoking status. Smoking status for this group of patients should be recorded in the preceding 12 months for SMOK002 until the end of the financial year in which the patient reaches the age of 25.

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).

Ex-smokers

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.

Vaccination and immunisations (VI)

Indicator	Points	Achievement thresholds	Points at lower threshold
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 (NICE 2020 menu ID: NM197)	18	90-95%	3
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 (NICE 2020 menu ID: NM198)	18	90-95%	7
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. (NICE 2020 menu ID: NM199)	18	87-95%	7
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 (based on NM201)	10	50-60%	-

Cervical screening (CS)

Indicator	Points	Achievement 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 (NICE 2017 menu ID: NM154)	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 (NICE 2017 menu ID: NM155)	4	45-80%

Section 2.3: Quality improvement domain (74 points)

Section 2.3 applies to all contractors participating in QOF.

Early cancer diagnosis

Indicator	Points	Achievement thresholds
QIECD005. The contractor can demonstrate continuous quality improvement activity focused on early cancer diagnosis as specified in the QOF guidance	27	NA
QIECD006. The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity focused on early cancer diagnosis as specified in the QOF guidance. This would usually include participating in a minimum of two peer review meetings	10	NA

Care of people with learning disabilities

Indicator	Points	Achievement thresholds
QILD007. The contractor can demonstrate continuous quality improvement activity focused on care of patients with a learning disability as specified in the QOF guidance	27	NA
QILD008. The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity focused on the care of patients with a learning disability as specified in the QOF guidance. This would usually include participating in a minimum of two network peer review meetings	10	NA

Section 3: Clinical domain

Atrial fibrillation (AF)

Indicator	Points	Achievement thresholds
Records		
AF001. The contractor establishes and maintains a register of patients with atrial fibrillation	5	
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) (NICE 2014 menu ID: NM81)	12	40-90%
AF007. In those patients with atrial fibrillation with a record of a CHA ₂ DS ₂ -VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (NICE 2014 menu ID: NM82)	12	40-70%

AF – rationale for inclusion of indicator set

AF is the most common sustained cardiac arrhythmia. Men are more commonly affected than women and the prevalence increases with age with prevalence in those over 65 years 7.2 per cent and over 75 years ten per cent.⁵

In people who have had a stroke, concurrent AF is associated with a higher rate of mortality, greater disability, a longer stay in hospital and a lower rate of discharge home.⁶

AF indicator 001

The contractor establishes and maintains a register of patients with atrial fibrillation

AF001.1 Rationale

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

AF 001.2 Reporting and verification

See indicator wording for requirement criteria.

⁵ NICE CG180. AF: management. 2014. <http://www.nice.org.uk/Guidance/CG180>

⁶ Lin HJ, Wolf PA, Helly-Hayes M et al 1996. Stroke severity in atrial fibrillation. The Framingham Study.

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.

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 AF.⁷ Contractors should consider the implications of this for individual patients before using the AF resolved code.

AF indicator 006 (NICE 2014 menu ID: NM81)

The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using CHA₂DS₂-VAS_c score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous CHADS₂ or CHA₂DS₂-VAS_c score of 2 or more)

AF 006.1 Rationale

The NICE guideline on atrial fibrillation⁸ recommends that people with symptomatic or asymptomatic paroxysmal, persistent or permanent AF, atrial flutter and/or a continuing risk of arrhythmia recurrence after cardioversion back to sinus rhythm should have an assessment of their stroke risk using the CHA₂DS₂-VAS_c risk assessment tool.

The CHA₂DS₂-VAS_c is a refinement of CHADS₂. The revised CHA₂DS₂-VAS_c 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)

AF 006.2 Reporting and verification

See indicator wording for requirement criteria.

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.

⁷ 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
<https://www.bmj.com/content/361/bmj.k1717>

⁸ NICE CG180 Atrial fibrillation (2014) <https://www.nice.org.uk/guidance/cg180>

AF indicator 007 (NICE 2015 menu ID: NM82)

In those patients with atrial fibrillation with a record of a CHA₂DS₂-VAS_c score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy

AF 007.1 Rationale

This indicator aims to support the identification of people with AF who are at increased risk of stroke so that they may be offered anti-coagulation drug therapy.

Around 1.2 million people in England are known to be at risk of stroke from AF,⁹ though it is estimated an additional 257,571 may be at-risk.¹⁰ Of these, around three-quarters are taking anti-coagulants in primary care.

An SSNAP audit has concluded that “if everyone with atrial fibrillation was treated with anticoagulants appropriately then about 6000 stroke would be prevented each year”.¹¹

All patients with AF and a CHA₂DS₂-VAS_c score of two or above should be offered anti-coagulation therapy taking their bleeding risk into account. A CHA₂DS₂-VAS_c score of one in women (women under age 65 with no other risk factors) should be regarded as low risk and should not receive anti-coagulation. Men with a CHA₂DS₂-VAS_c score of one should be regarded as at intermediate risk and a group in whom anti-coagulation should be considered.

Anti-coagulation may be with Apixaban, Dabigatran Etexilate, Rivaroxaban, Edoxaban or a vitamin K antagonist. Practices should not offer aspirin monotherapy solely for stroke prevention to people with AF. Aspirin is not as effective as anti-coagulants at preventing stroke in people with AF who are at increased risk of stroke and is also not as safe in terms of causing bleeding. Although the risks of anti-coagulation also increase with age, the evidence also shows that its benefits outweigh the risks in the vast majority of people with AF.

NICE provide a patient decision aid¹² to support discussions with patients as to the risks and benefits of taking anticoagulants.

AF 007.2 Reporting and verification

See indicator wording for requirement criteria.

The Business Rules will look for the latest CHA₂DS₂-VAS_c score in the patient record and if the score is equal to, or greater than two, the patient will be included in the denominator. If the patient does not have a CHA₂DS₂-VAS_c score, but does have a CHADS₂ score of greater than, or equal to two recorded before 1 April 2015, they will be included in the denominator.

⁹ NHS Digital. QOF 2015/16. <http://digital.nhs.uk/catalogue/PUB22266>

¹⁰ National Cardiovascular Intelligence Network. 2015. AF prevalence estimates for local populations. <https://www.gov.uk/government/publications/atrial-fibrillation-prevalence-estimates-for-local-populations>

¹¹ <https://www.strokeaudit.org/Documents/AnnualReport/4-Years-National-Summary-Report-v2.aspx>

¹² NICE. Patient decision aid. June 2014. <https://www.nice.org.uk/guidance/cg180/resources/patient-decision-aid-243734797>

Secondary prevention of coronary heart disease (CHD)

Indicator	Points	Achievement thresholds
Records		
CHD001. The contractor establishes and maintains a register of patients with coronary heart disease	4	
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 (NICE 2015 menu ID: NM88)	7	56–96%
CHD008. 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 (NICE 2013 menu ID: NM68)	12	40-77%
CHD009. The percentage of patients aged 80 years and over with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less (NICE 2019 menu ID: NM191)	5	46-86%

CHD – rationale for inclusion of indicator set

CHD is the single most common cause of premature death in the UK.¹³ The research evidence relating to the management of CHD is well established and if 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.

CHD indicator 001 (NICE 2019 menu ID: NM191)

The contractor establishes and maintains a register of patients with coronary heart disease

CHD 001.1 Rationale

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.

Contractors should record those with a history of myocardial infarction (MI) as well as those with a history of CHD.

CHD 001.2 Reporting and verification

See indicator wording for requirement criteria.

¹³ <https://www.bhf.org.uk/what-we-do/our-research/heart-statistics>

CHD indicator 005 (NICE 2015 menu ID: NM88)

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

CHD 005.1 Rationale

NICE guidelines¹⁴ 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.

CHD 005.2 Reporting and verification

See indicator wording for requirement criteria.

CHD indicator 008 (NICE 2013 menu ID: NM68)

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

CHD 008.1 Rationale

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

CHD008.2 Reporting and verification

See indicator wording for requirement criteria.

CHD indicator 009 (NICE 2019 menu ID: NM191)

The percentage of patients aged 80 years and over with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less

CHD 009.1 Rationale

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.¹⁵

CHD009.2 Reporting and verification

See indicator wording for requirement criteria.

¹⁴ NICE NG185 Acute coronary syndromes (2020) <http://guidance.nice.org.uk/NG185>

¹⁵ Hypertension in adults: diagnosis and management <http://www.nice.org.uk/guidance/ng136>

Heart failure (HF)

Indicator	Points	Achievement thresholds
Records		
HF001. The contractor establishes and maintains a register of patients with heart failure	4	
Initial diagnosis		
HF005. The percentage of patients with a diagnosis of heart failure on or after 1 April 2021 which: <ol style="list-style-type: none"> 1. Has been confirmed by an echocardiogram or by specialist assessment between 3 months before or 6 months after entering on to the register; or 2. If newly registered in the preceding 12 months, with no record of the diagnosis originally being confirmed by echocardiogram or specialist assessment, a record of an echocardiogram or a specialist assessment within 6 months of the date of registration (based on NM171)	6	50–90%
Ongoing management		
HF003. In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB (NICE 2019 menu ID: NM172)	6	60–92%
HF006. The percentage of patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, who are currently treated with a beta-blocker licensed for heart failure (NICE 2019 menu ID: NM173)	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 (Based NM174)	7	50-90%

HF – rationale for inclusion of indicator set

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.

HF indicator 001

The contractor establishes and maintains a register of patients with heart failure

HF 001.1 Rationale

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

HF 001.2 Reporting and verification

See indicator wording for requirement criteria.

There are two disease registers used for the HF indicators for the purpose of calculating APDF (practice prevalence):

- a register of patients with HF is used to calculate APDF for HF001, HF005, and HF007,
- a register of patients with HF due to left ventricular systolic dysfunction (LVSD) is used to calculate APDF for HF003 and HF006.

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.

HF indicator 005 (based on NM171)

The percentage of patients with a diagnosis of heart failure on or after 1 April 2021 which:

1. Has been confirmed by an echocardiogram or by specialist assessment between 3 months before or 6 months after entering on to the register; or
2. If newly registered in the preceding 12 months, with no record of the diagnosis originally being confirmed by echocardiogram or specialist assessment, a record of an echocardiogram or a specialist assessment within 6 months of the date of registration.

HF 005.1 Rationale

The aim of this indicator is to encourage practices to confirm diagnoses of heart failure and establish the underlying causes.

Symptoms and signs suggestive of heart failure are not always sufficient to make a definitive diagnosis and further investigation is usually required to confirm cardiac dysfunction and to identify causes. The NICE guideline for chronic heart failure recommends that the results of serum natriuretic peptides tests should be used to determine whether people with suspected heart failure should be referred onwards. People with raised serum natriuretic peptides 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 failure recommends that people with new suspected acute heart failure who have raised natriuretic peptides should have echocardiography within 48 hours of admission to hospital.

HF 005.2 Reporting and verification

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

HF indicator 003 (NICE 2019 menu ID: NM172)

In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB

HF 003.1 Rationale

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.

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.

NICE NG106¹⁶ 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.

HF 003.2 Reporting and verification

See indicator wording for requirement criteria.

HF indicator 006 (NICE 2019 menu ID: NM173)

HF006. The percentage of patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, who are currently treated with a beta-blocker licensed for heart failure

HF 006.1 Rationale

The NICE guideline for chronic heart failure¹⁷ 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).

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 treatment should

¹⁶ <https://www.nice.org.uk/guidance/ng106>

¹⁷ NICE NG106. Chronic heart failure.2018. <https://www.nice.org.uk/guidance/ng106>

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”.¹⁸

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.

HF 006.2 Reporting and verification

See indicator wording for requirement criteria.

Patients prescribed a beta-blocker unlicensed for heart failure before being given a diagnosis of heart failure will be excluded from this indicator.

HF indicator 007 (based on NM174)

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

HF 007.1 Rationale

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 if the clinical condition or medication has changed and longer intervals for stable people with heart failure.

HF 007.2 Reporting and verification

See indicator wording for requirement criteria.

Hypertension (HYP)

Indicator	Points	Achievement thresholds
Records		
HYP001. The contractor establishes and maintains a register of patients with established hypertension	6	
Ongoing management		
HYP003. 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 (NICE 2012 menu ID: NM53)	14	40-77%
HYP007. The percentage of patients aged 80 years and over with hypertension in whom the last blood pressure	5	40-80%

¹⁸ BNF. <http://www.evidence.nhs.uk/formulary/bnf/current>

reading (measured in the preceding 12 months) is 150/90 mmHg or less (NICE 2012 menu ID: NM54)		
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HYP – rationale for inclusion of indicator set

Hypertension is a common medical condition which is largely managed in primary care and represents a significant workload for GPs and the primary care team. Trials of anti-hypertensive treatment have confirmed a significant reduction in the incidence of stroke and CHD in patients with treated hypertension.

HYP indicator 001

The contractor establishes and maintains a register of patients with established hypertension

HYP 001.1 Rationale

Effective treatment of hypertension aims to reduce the risk of cardiovascular problems such as heart attacks and strokes.

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.

NICE NG136¹⁹ uses the following definitions:

Stage 1 hypertension

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

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 of severe hypertension

Clinic systolic blood pressure of 180 mmHg or higher or clinic diastolic blood pressure of 120 mmHg or higher.

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.

For patients aged 39 or under with stage 1 hypertension and no evidence of target organ damage, CVD, renal disease or diabetes, NICE recommend that practitioners consider seeking specialist evaluation of secondary causes of hypertension and a

¹⁹ NICE NG136. Hypertension in adults: diagnosis and management. 2019
<https://www.nice.org.uk/guidance/ng136>

more detailed assessment of potential target organ damage. This is because 10-year cardiovascular risk assessments can underestimate the lifetime risk of cardiovascular events in these patients.

HYP 001.2 Reporting and verification

See indicator wording for requirement criteria.

The contractor may be required by commissioners to discuss their plans for ensuring that new diagnoses are confirmed using ABPM or HBPM as appropriate.

HYP indicator 003 (NICE 2012 menu ID: NM53)

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.

HYP003.1 Rationale

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.

HYP003.2 Reporting and verification

See indicator wording for requirement criteria.

HYP indicator 007 (NICE 2012 menu ID: NM54)

The percentage of patients aged 80 years and over with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less.

HYP007.1 Rationale

The NICE guideline for hypertension²⁰ recommends that patients aged 80 years and over with hypertension should be treated to a target blood pressure of 150/90 mmHg or less. 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.

Where people have had a lower treatment target before the age of 80 years their treatment should continue and not be adjusted or back 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.

HYP007.2 Reporting and verification

See indicator wording for requirement criteria.

²⁰ NICE NG136. Hypertension in adults: diagnosis and management. 2019
<http://www.nice.org.uk/guidance/ng136>

Peripheral arterial disease (PAD)

Indicator	Points	Achievement thresholds
Records		
PAD001. The contractor establishes and maintains a register of patients with peripheral arterial disease (NICE 2011 menu ID: NM32)	2	

PAD – rationale for inclusion of indicator set

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.

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.

Further information

NICE CG147. PAD: diagnosis and management. 2012.

<https://www.nice.org.uk/guidance/cg147>

PAD indicator 001 (NICE 2011 menu ID: NM32)

The contractor establishes and maintains a register of patients with peripheral arterial disease

PAD 001.1 Rationale

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.

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.

PAD 001.2 Reporting and verification

See indicator wording for requirement criteria.

Stroke and TIA (STIA)

Indicator	Points	Achievement thresholds
Records		
STIA001. The contractor establishes and maintains a register of patients with stroke or TIA	2	
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 (NICE 2015 menu ID: NM94)	4	57–97%
STIA010. The percentage of patients aged 79 years or less 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 (NICE 2013 menu ID: NM69)	3	40-73%
STIA011. The percentage of patients aged 80 years and over with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less (based on NM93)	2	46-86%

STIA – rationale for inclusion of indicator set

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 outcomes.²¹

STIA indicator 001

The contractor establishes and maintains a register of patients with stroke or TIA

STIA 001.1 Rationale

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

²¹ Stroke and transient ischaemic attack in over 16s: diagnosis and initial management
<http://www.nice.org.uk/guidance/ng128>

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.

STIA 001.2 Reporting and verification

See indicator wording for requirement criteria.

STIA indicator 007 (NICE 2015 menu ID: NM94)

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

STIA 007.1 Rationale

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.

The British National Formulary (BNF)²² 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).”

Further information - NICE technology appraisal (TA) TA210. Clopidogrel and modified-release dipyridamole for the prevention of occlusive vascular events. 2010.

<http://www.nice.org.uk/guidance/TA210>

STIA 007.2 Reporting and verification

See indicator wording for requirement criteria.

STIA indicator 010 (NICE 2013 menu ID: NM69)

The percentage of patients aged 79 years or less 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

²² BNF stroke treatment summary. <https://bnf.nice.org.uk/treatment-summary/stroke.html>

STIA 010.1 Rationale

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.

The NICE guideline on hypertension²³ 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.

STIA 010.2 Reporting and verification

See indicator wording for requirement criteria.

STIA indicator 011 (based on NM93)

The percentage of patients aged 80 years and over with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less

STIA011.1 Rationale

This indicator measures the intermediate outcome of a blood pressure of 150/90 mmHg or less in people age 80 years and over with a history of stroke or TIA. The aim of treating people to this target is to promote secondary prevention of vascular events through satisfactory blood pressure control.

STIA011.2 Reporting and verification

See indicator wording for requirement criteria.

Diabetes mellitus (DM)

Indicator	Points	Achievement 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 (<i>NICE 2011 menu ID: NM41</i>)	6	
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%

²³ NICE NG 136. Hypertension in adults: diagnosis and management. 2019. <https://www.nice.org.uk/guidance/ng136>

<i>(NICE 2015 menu ID: NM95)</i>		
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 <i>(NICE 2010 menu ID: NM13)</i>	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 <i>(NICE 2011 menu ID: NM27)</i>	11	40–90%
DM019. 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 140/80 mmHg or less <i>(NICE 2018 menu ID: NM159)</i>	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 <i>(NICE 2018 menu ID: NM157)</i>	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 <i>(NICE 2018 menu ID: NM158)</i>	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) <i>(NICE 2018 menu ID: NM162)</i>	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 <i>(NICE 2018 menu ID: NM163)</i>	2	50-90%

DM – rationale for inclusion of indicator set

Diabetes mellitus (DM) is one of the common endocrine diseases affecting all age groups with over one million people in the UK 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.

Further information:

NICE NG28. Type 2 diabetes in adults: management. 2015 updated 2019.
<http://www.nice.org.uk/guidance/NG28>

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

NICE NG18. Diabetes (type 1 and type 2) in children and young people: diagnosis and management. 2015 updated 2016. <http://www.nice.org.uk/guidance/NG18>

NICE NG17. Type 1 diabetes in adults: diagnosis and management. 2015 updated 2016. <http://www.nice.org.uk/guidance/NG17>

The English National Service Framework (NSF) for Diabetes website²⁴ also includes details of the evidence behind a range of recommendations.

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 of these items, but it is the contractor's responsibility to ensure that they have been done.

DM indicator 017 (NICE 2017 menu ID: NM41)

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

DM 017.1 Rationale

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 England.²⁵ 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 types of diabetes within the proposed algorithm. Women with gestational diabetes are excluded from this indicator set.

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

²⁴ DH. <https://www.gov.uk/government/publications/national-service-framework-diabetes>

²⁵ RCGP and NHS Diabetes. Coding, classification and diagnosis of diabetes. 2011.

their specific type of diabetes is confirmed. This is advised to be within six to 12 months of the initial diagnosis of diabetes mellitus.

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 also 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.

The World Health Organisation (WHO) 2006²⁶ 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.

In 2011 an addendum to the 2006 WHO diagnostic criteria was published to allow the use of glycated haemoglobin (HbA1c) in diagnosing DM.²⁷ 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. The WHO expert group concluded that there is currently insufficient evidence to make any formal recommendation on the interpretation of HbA1c levels below 48 mmol/mol (6.5 per cent).

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).

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).

The Business Rules include a clinical code for “diabetes in remission”. Successful management of diabetes with lifestyle, medication, pancreatic or islet cell transplant and/or bariatric surgery may result in glucose levels falling below those diagnostic of diabetes. However, these people may still experience the macrovascular and microvascular complications of diabetes and therefore need continued monitoring. Experts from the diabetes classification working group have endorsed the use of this code for people where treatment has normalised hyperglycaemia but still require continued monitoring.

²⁶ WHO. Definition and diagnosis of DM and intermediate hyperglycaemia. 2006.

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

²⁷ 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

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.

DM 017.2 Reporting and verification

See indicator wording for requirement criteria.

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.

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.

DM indicator 006 (NICE 2015 menu ID: NM95)

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)

DM 006.1 Rationale

NICE guidelines^{28 29} recommend the use of ACE-I (or ARBs) to slow the progression of renal disease in patients with diabetes and trial evidence suggests that these are most effective when given in the maximum dose quoted in the BNF. Although trial evidence is based largely on ACE-I, it is believed that similar benefits occur from treatment with ARBs in patients who are intolerant of ACE-I.

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.

DM 006.2 Reporting and verification

See indicator wording for requirement criteria.

DM indicator 012 (NICE 2010 menu ID: NM13)

The percentage of patients with diabetes, on the register, with a record of 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

DM 012.1 Rationale

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 at most risk.

²⁸ NICE NG17. Type 1 diabetes in adults. 2015 updated 2016. <https://www.nice.org.uk/guidance/ng17>

²⁹ NICE NG28. Type 2 diabetes in adults: management. 2015 updated 2019. <https://www.nice.org.uk/guidance/ng28>

The NICE guideline on diabetic foot problems³⁰ outlines foot risk classification.

For the purposes of QOF the clinical codes for 'moderate risk' are used to record the concept of 'increased risk'.

DM 012.2 Reporting and verification

See indicator wording for requirement criteria.

DM indicator 014 (NICE 2011 menu ID: NM27)

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

DM 014.1 Rationale

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. 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. The indicator requires that SE is offered (preferably through a group education programme) to every person with diabetes and/or their carer from the time of diagnosis, with annual reinforcement and review. An alternative education programme of equal standard may be offered to people unable or unwilling to participate in group education sessions.

From the start of 2021/22, there is expected to be a phased roll-out of the Healthy Living in Diabetes Programme (HeLP). Referral to this programme will also meet the criteria for this indicator.

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.

DM 014.2 Reporting and verification

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

Where services are not available locally, practices would be expected to discuss this with the CCG and encourage the commissioning of the relevant services. This may take some time so practices may wish to consider whether it would be appropriate to offer the service in-house, or to services available in different CCGs or neighbouring practices etc.

³⁰ NICE NG19 Diabetic foot problems: prevention and management 2015 updated 2019. <http://www.nice.org.uk/guidance/NG19/>

DM indicator 019 (NICE 2018 menu ID: NM159)

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 140/80 mmHg or less

DM019.1 Rationale

Lowering blood pressure in people with diabetes reduces the risk of developing micro and macrovascular complications.

Applying universal BP targets to all people with diabetes may inadvertently lead to the potential for undertreatment in those with less complex need and overtreatment in those with complex needs and co-morbidity.³¹ This indicator focuses on 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.

Contractors should note that the BP target in this indicator is higher than that recommended for patients with Type 1 diabetes in NG17, where they should be aiming for 135/85mmHg or 130/80mmHg if the person has albuminuria or two or more features of metabolic syndrome. It is also a lower target than that recommended for patients with type 2 diabetes. Contractors should use their clinical judgement when setting individual blood pressure targets, particularly for people aged 80 years and over.

DM019.2 reporting and verification

See indicator wording for requirement criteria.

DM indicator 020 (NICE 2018 menu ID: NM157)

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

DM020.1 Rationale

Glycated haemoglobin (HbA1c) is commonly used to monitor glucose control as it provides a measure of average plasma glucose 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.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.

DM020.2 Reporting and verification

See indicator wording for requirement criteria.

DM indicator 021 (NICE 2018 menu ID: NM158)

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

DM021.1 Rationale

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 in order to avoid people becoming symptomatic of hyperglycaemia.

DM021.2 Reporting and verification

See indicator wording for requirement criteria.

DM indicator 022 (NICE 2018 menu ID: NM162)

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)

DM022.1 Rationale

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 have had diabetes for more than 10 years, or they have established nephropathy or other CVD risk factors. 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 QRISK2 assessment tool.

³³ NICE NG17 Type 1 diabetes in adults: diagnosis and management 2015 updated 2016
<http://www.nice.org.uk/guidance/NG17>

³⁴ NICE NG28 Type 2 diabetes in adults: management 2015 updated 2019
www.nice.org.uk/guidance/NG28

³⁵ NICE CG181 Cardiovascular disease: risk assessment and reduction, including lipid modification 2014 updated 2016 <https://www.nice.org.uk/guidance/cg181>

In September 2016, the NICE guideline for cardiovascular risk assessment and lipid modification was amended and reinforced its recommendation of high-intensity statin treatment, for primary prevention (atorvastatin 20mg) and secondary prevention (atorvastatin 80mg).

DM022.2 Reporting and verification

See indicator wording for requirement criteria.

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.

DM indicator 023 (NICE 2018 menu ID: NM163)

The percentage of patients with diabetes and a history of cardiovascular disease (excluding haemorrhagic stroke) who are currently treated with a statin

DM023.1 Rationale

The NICE guideline for cardiovascular disease risk assessment and lipid modification³⁵ recommends that high intensity statin therapy be considered for the secondary prevention of CVD. Stain therapy helps 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 should be used. This indicator wording allows for the selection of an appropriate and individualised dosage.

DM023.2 Reporting and verification

See indicator wording for requirement criteria.

Asthma (AST)

Indicator	Points	Achievement 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 <i>(based on NM165)</i>	4	
Initial diagnosis		
AST006. The percentage of patients with a diagnosis of asthma on or from 1 April 2021 with either: <ol style="list-style-type: none"> 1. a record of spirometry and one other objective test (FeNO or reversibility or 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 	15	45–80%

April 2021 but no record of objective tests being performed at the date of registration, with a record of spirometry and one other objective test (FeNO or reversibility or variability) recorded within 6 months of registration <i>(based on NM166)</i>		
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 <i>(based on NM167)</i>	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 <i>(based on NM168)</i>	6	45–80%

AST – rationale for inclusion of indicator set

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

AST indicator 005 (based on NM165)

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

AST 005.1 Rationale

The diagnosis of asthma is a clinical one; there is no confirmatory diagnostic blood test, radiological investigation or histopathological investigation. In most patients, the diagnosis can be corroborated by suggestive changes in lung function tests.

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 limitation and reversibility. Obstructive airways disease produces a decrease in peak expiratory flow (PEF) and forced expiratory volume in one second (FEV₁) but which persist 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. If repeatedly normal in the presence of symptoms, then a diagnosis of asthma is in doubt.

A proportion of patients with COPD will also have asthma, e.g. they have large reversibility – 400mls or more on FEV₁ – but do not return to over 80 per cent predicted and have a significant smoking history. These patients will be recorded on both the asthma and COPD registers.

Children

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.

In school children, bronchodilator responsiveness, PEF variability or tests of bronchial hyperactivity may be used to confirm the diagnosis, with the same reservations as above.

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.

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.

This produces a significant challenge for the 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.

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.

Further information - SIGN guideline 158. SIGN and BTS. British guideline on the management of asthma. 2016.³⁶ NICE guideline NG80: Asthma: diagnosis, monitoring and chronic asthma management.³⁷

AST 005.2 Reporting and verification

See indicator wording for requirement criteria.

Part of the register criteria for asthma is based on appropriate prescribing of therapies. From October 2014, the Business Rules were updated to exclude drug therapies licensed only for use in patients with a diagnosis of COPD as they are not licensed as a treatment for asthma.

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

³⁶ <https://www.sign.ac.uk/our-guidelines/british-guideline-on-the-management-of-asthma/>

³⁷ [Overview | Asthma: diagnosis, monitoring and chronic asthma management | Guidance | NICE](#)

in prescribing should only be done where clinically appropriate.

AST indicator 006 (based on NM166)

The percentage of patients with a diagnosis of asthma on or from 1 April 2021 with either:

1. a record of spirometry and one other objective test (FeNO or reversibility or 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 2021 but no record of objective tests being performed at the date of registration, with a record of spirometry and one other objective test (FeNO or reversibility or variability) recorded within 6 months of registration.

AST 006.1 Rationale

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 to a specialist service for the necessary diagnostic tests to be completed. Results of testing should inform subsequent treatment for people with asthma and lead to improved health and wellbeing.

Spirometry is the key investigation for distinguishing obstructive and restrictive respiratory conditions and will determine subsequent investigations.³⁸ It is crucial that diagnostic spirometry is performed to published quality standards^{39,40} and therefore referral to a specialist service may be required.

Adults (aged 17 and over) should be diagnosed, if they have symptoms suggestive of asthma and:

- 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 level.⁴¹

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/>

⁴¹ NICE national guidance NG80 Asthma: diagnosis, monitoring and chronic asthma management. 2017. <http://www.nice.org.uk/guidance/ng80>

Referral may be required for FeNO testing.

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.

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

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

Further information about the diagnosis of asthma is provided in the National Guideline Asthma: diagnosis, monitoring and chronic asthma management.⁴²

Co-morbidity: asthma and COPD

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 reversibility.⁴³

AST 006.2 reporting and verification

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

AST indicator 007 (based on NM167)

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

AST 007.1 Rationale

This indicator aims to encourage the use of validated asthma questionnaires, recording of the number of exacerbations, and written action plans in annual asthma reviews. These reviews can help identify people at increased risk of poor outcomes and allow them to use information from their review to self-manage their asthma and maximise their future health.

⁴² NICE national guidance NG80 Asthma: diagnosis, monitoring and chronic asthma management. 2017. <http://www.nice.org.uk/guidance/ng80>

⁴³ NICE NG115. COPD in over 16s: diagnosis and management. 2018. <https://www.nice.org.uk/guidance/NG115>

The BTS/SIGN clinical guideline⁴⁴ proposes a structured system for recording inhaler technique, morbidity, PEF levels, current treatment and asthma action plans.

QOF explicitly requires an assessment of asthma control using a validated asthma control questionnaire using the Asthma Control Questionnaire⁴⁵ or Asthma Control Test,⁴⁶ a recording of the number of exacerbations, an assessment of inhaler technique and a written personalised action plan.

If the asthma appears to be uncontrolled, take in 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.

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).⁴⁷

AST 007.2 Reporting and verification

See indicator wording for requirement criteria.

The Business Rules **allow** contractors **to** code **the number of exacerbations and** the assessment of asthma control using the Asthma Control Questionnaire or the Asthma Control Test **up to one month before the asthma review is completed**. The provision of a written personalised asthma plan **should be** recorded **on the same day as the asthma review** in order to meet the requirements of this indicator.

AST indicator 008 (based on NM168)

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

AST 008.1 Rationale

There are very few studies that have considered the question of whether smoking affects asthma severity.⁴⁸ 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 control⁴⁹.

⁴⁴ BTS/SIGN clinical guideline 158. Management of asthma. 2019. <https://www.sign.ac.uk/our-guidelines/british-guideline-on-the-management-of-asthma/>

⁴⁵ <https://www.qoltech.co.uk/acq.html>

⁴⁶ <https://www.asthma.com/additional-resources/asthma-control-test.html>

⁴⁷ <https://www.rcplondon.ac.uk/projects/national-review-asthma-deaths>

⁴⁸ <https://erj.ersjournals.com/content/41/3/716>

⁴⁹ Price et al. ClinExp Allergy 2005; 35: 282-287

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 secondhand smoke for those with asthma, and how to access smoking cessation services.

AST 008.2 Reporting and verification

See indicator wording for requirement criteria.

Chronic obstructive pulmonary disease (COPD)

Indicator	Points	Achievement thresholds
Records		
COPD009. 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 2021 and 2. Patients with a clinical diagnosis of COPD on or after 1 April 2021 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 in the preceding 12 months 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 2021 who are unable to undertake spirometry (based on NM169) 	8	
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 (NICE 2019 menu ID: NM170)	9	50–90%
COPD008. 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 an offer of referral to a pulmonary rehabilitation programme (excluding those who have previously attended a pulmonary rehabilitation programme) (NICE 2012 menu ID: NM47)	2	40-90%

COPD – rationale for inclusion of indicator set

COPD is a common disabling condition with a high mortality. The most effective treatment is smoking cessation. Oxygen therapy has been shown to prolong life in the later stages of the disease and has also been shown to have a beneficial impact on exercise capacity and mental state. Some patients respond to inhaled steroids. Many patients respond symptomatically to inhaled beta-agonists and anti-cholinergics. Pulmonary rehabilitation has been shown to produce an improvement in quality of life.

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.

COPD indicator 009 (based on NM169)

The contractor establishes and maintains a register of:

1. Patients with a clinical diagnosis of COPD before 1 April 2021 and
2. Patients with a clinical diagnosis of COPD on or after 1 April 2021 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 in the preceding 12 months 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 2021 who are unable to undertake spirometry

COPD 009.1 Rationale

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 management.⁵⁰ 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.

COPD 009.2 Reporting and verification

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 in the diagnostic range will increase relative to those without spirometry recorded.

Where patients have co-existing COPD and asthma they will be included on both disease registers. Approximately 15 per cent of patients with COPD will also have asthma.

⁵⁰NICE NG115. Chronic obstructive pulmonary disease in over 16s. 2018 updated 2019
<https://www.nice.org.uk/guidance/ng115>

COPD indicator 0010 (NICE 2019 menu ID: NM170)

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

COPD 0010.1 Rationale

This indicator aims to encourage the use of recording of number of exacerbations and assessments of breathlessness in annual COPD reviews. Understanding the frequency of exacerbations can help when creating personalized management plans, identifying triggers and avoiding future exacerbations.

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:

- number of exacerbations
- the degree of breathlessness (Medical Research Council [MRC] dyspnoea scale).

A tool such as the COPD Assessment Test (CAT) could be used to assess current health status.

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 during any review.

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.

COPD 0010.2 Reporting and verification

See indicator wording for requirement criteria.

COPD indicator 008 (NICE 2012 menu ID: NM47)

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 an offer of referral to a pulmonary rehabilitation programme (excluding those who have previously attended a pulmonary rehabilitation programme).

COPD 008.1 Rationale

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.

The NICE guideline for COPD⁵¹ 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.

Medical management should be optimised before referral.

COPD 008.2 reporting and verification

See indicator wording for requirement criteria.

Patients who have previously attended a pulmonary rehabilitation programme will be excluded from the denominator for this indicator.

Where practices do not have locally commissioned pulmonary rehabilitation programmes they may exclude patients from the denominator using the specific service unavailable codes.

Dementia (DEM)

Indicator	Points	Achievement thresholds
Records		
DEM001. The contractor establishes and maintains a register of patients diagnosed with dementia	5	
Ongoing management		
DEM004. The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (NICE 2015 menu ID: NM107)	39	35–70%

DEM – rationale for inclusion of indicator set

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 62 per cent of cases of dementia with vascular dementia accounting for around 17 per cent.^{52,53}

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

⁵¹ Chronic obstructive pulmonary disease in over 16s: diagnosis and management | Guidance | NICE <https://www.nice.org.uk/guidance/NG115>

⁵² Alzheimer’s Society. Dementia UK: update 2014.

⁵³ NICE NG97 Dementia: assessment, management and support for people living with dementia and their carers. 2018. <https://www.nice.org.uk/guidance/ng97>

men due to the longer lifespan of women. Other types of dementia such as Lewy Body dementia and fronto-temporal dementia are relatively rare but can be very distressing.

DEM indicator 001

The contractor establishes and maintains a register of patients diagnosed with dementia

DEM 001.1 Rationale

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.

DEM 001.2 Reporting and verification

See indicator wording for requirement criteria.

DEM indicator 004 (NICE 2015 menu ID: NM107)

The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months

DEM 004.1 Rationale

The NICE guideline for dementia⁵⁴ recommends agreeing care plans with health and social services for people who have dementia, and having formal reviews at agreed frequencies

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.

The face-to-face care plan or advanced care plan review focuses on support 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:

- an appropriate physical, mental health and social review for the patient,
 - 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); and
1. obtain 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

⁵⁴ NICE NG97 Dementia: assessment, management and support for people living with dementia and their carers.2018. <https://www.nice.org.uk/guidance/ng97>

- for information commensurate with the stage of the illness and his or her and the patient's health and social care needs,
2. as appropriate, the carer should be included in the care plan or advanced care plan discussions,
 3. if applicable, the impact of caring on the care-giver,
 4. offer the carer a health check⁵⁵ to address any physical and mental health impacts, including signposting to any other relevant services to support their health and wellbeing.

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 minutes.⁵⁶ Ideally the first such appointment would be within six months of diagnosis.

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 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 without.⁵⁷

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 dementia.⁵⁸ As the illness progresses, needs may change and the review may focus more on issues such as respite care.

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.

⁵⁵ 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.

⁵⁶ 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.

⁵⁷ Alzheimers society: Apathy, anxiety and depression. 2017

⁵⁸ Eccles et al. BMJ 1998; 317: 802-808

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. Dementia: assessment, management and support for people living with dementia and their carers. 2018 <https://www.nice.org.uk/guidance/ng97>

NICE QS184: Dementia. 2019. <https://www.nice.org.uk/guidance/qs184>

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 public health guidance 16. Mental wellbeing in over 65s occupational therapy and physical activity interventions. 2008. <https://www.nice.org.uk/guidance/ph16>

NHS Choices. Looking after someone with dementia. 2015.

<https://www.nhs.uk/conditions/dementia/carers/>

DEM 004.2 Reporting and verification

See indicator wording for requirement criteria.

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.

Depression (DEP)

Indicator	Points	Achievement thresholds
Initial management		
DEP003. 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 (<i>based on NM50</i>)	10	45–80%

DEP – rationale for inclusion of the indicator set

Depression is common and disabling.

In 2012, the estimated prevalence for a depressive episode among people aged 16 or over and under the age of 74 in England was 2.5 per cent. If the broader and less specific category of 'mixed depression and anxiety' is included, these figures

increase dramatically to 8.9 per cent.^{59 60} 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 diseases.⁶¹ 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 other public sector costs are included this figure is estimated at between £20.2-23.8 billion a year.⁶²

DEP indicator 003 (based on NICE 2012 menu ID: NM50)

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

DEP 003.1 Rationale

The NICE guideline on depression in adults⁶³ states that patients with mild depression or sub-threshold symptoms be reviewed and re-assessed after initial presentation, normally within two weeks.

It recommends that patients with mild or moderate depression who start antidepressants are reviewed after one week if they are considered to present an increased risk of suicide or after two weeks if they are not considered at increased risk of suicide. 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.

This indicator promotes a single depression review between ten and 56 days inclusive after the date of diagnosis. For some patients this may not be their first review as they will have been reviewed initially within a week of the diagnosis. Unless a patient's symptoms have resolved, further reviews may be required.

When assessing a person who may have depression, conduct a comprehensive assessment that does not rely simply on a symptom count. Take into account both the degree of functional impairment and/or disability associated with the possible depression and the duration of the episode.

⁵⁹ NICE CG90. Depression in adults: recognition and management. 2009 updated 2018
<https://www.nice.org.uk/guidance/CG90>

⁶⁰ PHE. Fingertips data. Common mental health disorders. 2012. <http://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders/data#page/0/gid/8000026/pat/6/par/E12000004/ati/102/are/E06000015/iid/90419/age/240/sx/4>

⁶¹ 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.

⁶² DH. No health without mental health – supporting document. 2011.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

⁶³ NICE CG90. Depression in adults: recognition and management. 2009 updated 2018
<https://www.nice.org.uk/guidance/CG90>

Only face-to-face or telephone contact with a clinician is acceptable to meet the requirements for this indicator.

DEP 003.2 Reporting and verification

See indicator wording for requirement criteria.

Those patients whose ongoing care is being provided by specialist mental health services may have a personalised care adjustment applied.

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.

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.

The register for the purpose of calculating the APDF is defined as all patients aged 18 or over, diagnosed on or after 1 April 2006, who have an unresolved record of depression in their patient record.

Verification – Commissioners may ask contractors about the percentage of telephone reviews conducted and who they were delivered by.

Mental health (MH)

Indicator	Points	Achievement 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	
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 (<i>NICE 2015 menu ID: NM108</i>)	6	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 (<i>based on NM17</i>)	4	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 (based on NM16)	4	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 (based on NM15)	4	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 who 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 (based on NM129)	8	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 (NICE 2015 menu ID: NM130)	8	50-90%

MH – rationale for inclusion of indicator set

This indicator set reflects the complexity of mental health problems, and the complex mix of physical, psychological and social issues that present to GPs.

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.

This indicator set focuses on patients with severe mental illness (SMI). There are separate indicator sets that focus on patients with depression and dementia.

NICE CG178⁶⁴ recommends primary care utilise registers to monitor the physical health of patients with psychosis or schizophrenia.

NICE CG185⁶⁵ 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

⁶⁴ NICE CG178. Psychosis and schizophrenia in adults: prevention and management. 2014. <http://www.nice.org.uk/guidance/CG178>

⁶⁵ NICE CG185. Bipolar disorder: assessment and management. 2014. <http://www.nice.org.uk/guidance/CG185>

- 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.

For 2021/22, QOF will include all six elements of the comprehensive annual physical health check for patients with schizophrenia, bipolar affective disorder and other psychoses as defined in the NHS Long Term Plan.

In addition to lifestyle factors, such as smoking, poor diet and lack of exercise, antipsychotic drugs vary in their liability for metabolic side effects such as weight gain, lipid abnormalities and disturbance of glucose regulation. Specifically, they increase the risk of the metabolic syndrome, a recognised cluster of features (hypertension, central obesity, glucose intolerance or insulin resistance or dyslipidaemia) which is a predictor of type 2 diabetes and CHD.⁶⁶

Due to the combination of lifestyle factors and side effects of antipsychotic medication, there is a high incidence of cardiovascular disease (CVD) causing premature death in people with SMI (15 years for bipolar disorder and 25 years for schizophrenia). The aim of the comprehensive annual physical health check is to identify and address risk factors for CVD.⁶⁷

Further information

NICE guidance (CG178) Psychosis and schizophrenia in adults: prevention and management 2014

<https://www.nice.org.uk/guidance/cg178/chapter/recommendations#how-to-use-antipsychotic-medication>

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

MH indicator 001

The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy

MH 001.1 Rationale

The register includes all patients with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy.

Patients on lithium therapy are defined as patients with a prescription for lithium within the preceding six months.

⁶⁶ Mackin P, Bishop D, Watkinson H et al. Metabolic disease and cardiovascular risk in people treated with antipsychotics in the community. 2007. BJP 191: 23-9.

⁶⁷ Overview | Psychosis and schizophrenia in adults: prevention and management | Guidance | NICE <https://www.nice.org.uk/guidance/CG178>

Remission from severe mental illness

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 of them from the associated indicators because their illness is in remission.

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 per cent of patients recovered from psychotic illnesses to some extent, although only 16 per cent recover if a more stringent concept of recovery⁶⁸ is used.

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

Where a patient is recorded as being 'in remission' they remain on the register (in case their condition relapses at a later date) but they are excluded from the denominator for subsequent indicators.

The accuracy of this diagnosis and the coding should be reviewed on an annual basis by a GP. If a patient who has been coded as 'in remission' experiences a relapse then this should be recorded as such in their patient record.

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

MH 001.2 Reporting and verification

See indicator wording for requirement criteria.

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' and to confirm the ongoing accuracy of this coding.

Contractors may be expected to demonstrate they have a protocol to guide their clinicians as to how this would work 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 as to when to enter this code.

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.

MH indicator 002 (NICE 2015 menu ID: NM108)

The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the records, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate

MH 002.1 Rationale

This indicator reflects good professional practice and is supported by NICE CG178.⁶⁹

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 may include the views of their relative(s) or carer(s) where appropriate.

Up to half of patients who have a severe mental illness are seen only in a primary care setting. For these patients, it is important that the primary care team takes responsibility for discussing and documenting a care plan in their primary care record.

When constructing the primary care record, research supports the inclusion of the following information:

- patient's current health status and social care needs including how needs are to be met, by whom and the patient's expectations
- how socially supported the individual is: e.g. friendships/family contacts/voluntary sector organisation involvement.
- co-ordination arrangements with secondary care and/or mental health services and a summary of what services are actually being received
- occupational status – for people being supported by secondary mental health services in England, there is a 65% employment gap compared with the general population.⁷⁰ Studies show a clear interest in work and employment activities among users of mental health services with up to 90 per cent wishing to go into or back to work.⁷¹
- 'Early warning signs' from the patient's perspective that may indicate a possible relapse.⁷² Many patients may already be aware of their early warning signs (or relapse signature) but it is important for the primary care team to also be aware of noticeable changes in thoughts, perceptions, feelings and behaviours leading up to their most recent episode of illness as well as any events the patient thinks may have acted as triggers.
- the patient's preferred course of action (discussed when well) in the event of a clinical relapse, including who to contact and wishes around medication.

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

⁷⁰ <https://www.longtermplan.nhs.uk/online-version/appendix/health-and-employment/>

⁷¹ See Grove and Drurie. Social firms: an instrument for social and economic inclusion. Redhill, Social Firms UK. 1999.

⁷² Birchwood et al. Advances in Psychiatric Treatment. 2000; 6: 93-101 and Birchwood and Spencer. Clinical Psychology Review. 2001; 21(8): 1211-26

If a patient is treated under the care programme approach (CPA), then they have a documented care plan discussed with their community key worker available. This is acceptable for the purposes of QOF provided the practice has evidence of a review having taken place with the community key worker and the patient treated under the CPA.

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.

MH 002.2 Reporting and verification

See indicator wording for requirement criteria.

Verification – Commissioners may require contractors to randomly select a number of care plans to ensure that they are being maintained annually.

MH indicator 003 (based on NM17)

The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months

MH 003.1 Rationale

Patients with schizophrenia have mortality between two and three times that of the general population and most of the excess deaths are from diseases that are the major causes of death in the general population. 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 cardiovascular mortality of schizophrenia has increased over the past 25 years relative to the general population.⁷³ 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.

Hypertension in people with schizophrenia is estimated at 19 per cent compared with 15 per cent in the general population.⁷⁴ A cross-sectional study of 4310 patients diagnosed with bipolar disorder in 2001 receiving care at veterans' administration facilities found a prevalence of hypertension of 35 per cent.⁷⁵

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, patients with schizophrenia and other attendees indicated that general practice were less likely to screen patients with schizophrenia for cardiovascular risk compared with the other two groups.⁷⁶

⁷³ Brown S, Kim M, Mitchell C et al. 25 year mortality of a community cohort with schizophrenia. *BJP*. 2010. 196: 116-21.

⁷⁴ Hennekens C, Hennekens A, Hollar D. Schizophrenia and increased risks of CVD. 2005. *Am Heart Journal* 150: 1115-21

⁷⁵ Kilbourne AM, Cornelius JR, Han X et al. Burden of general medical conditions among individuals with bipolar disorder. 2004. *Bipolar Disorder* 6: 368-73

⁷⁶ 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

Recording (and treating) cardiovascular risk factors are therefore very important for patients with a serious mental illness.

MH 003.2 Reporting and verification

See indicator wording for requirement criteria.

MH indicator 006 (based on NM16)

The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months

MH006.1 Rationale

As noted above, people with serious mental illness are at increased risk of premature and preventable cardiovascular mortality and morbidity when compared to the general population. Obesity is a key risk factor linked to this. When compared to the general population people with psychosis lead more sedentary lives, eat less fruit and vegetables, are more likely to be obese and to smoke. In addition to these lifestyle factors, antipsychotic drugs vary in their liability for metabolic side effects such as weight gain, lipid abnormalities and disturbance of glucose regulation. Specifically, they increase the risk of metabolic syndrome, a recognised cluster of features (hypertension, central obesity, glucose intolerance or insulin resistance and dyslipidaemia), which is a predictor of type 2 diabetes and coronary heart disease.

About 40% of people with schizophrenia are obese and obesity is also common in people with bipolar disorders. NICE Guidelines CG178⁷⁷ and CG185⁷⁸ recommend annual weight monitoring in this patient group.

MH006.2 Reporting and verification

See indicator wording for requirement criteria.

MH indicator 007 (based on NM15)

The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months.

MH 007.1 Rationale

Substance misuse by people with schizophrenia is increasingly recognised as a major problem, both in terms of its prevalence and its clinical and social effects.⁷⁹ The National Psychiatric Morbidity Survey in England found that 16 per cent of people with schizophrenia were drinking over the recommended limits of 21 units of

⁷⁷ NICE CG 178 Psychosis and schizophrenia in adults: prevention and management. 2014. <http://www.nice.org.uk/guidance/cg178>

⁷⁸ NICE CG185 Bipolar disorder: assessment and management. 2014 updated 2018 <http://www.nice.org.uk/guidance/cg185>

⁷⁹ 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 for men and 14 units of alcohol for women a week.^{80 81} Bipolar affective disorder is also highly co-morbid with alcohol and other substance abuse.⁸²

MH 007.2 Reporting and verification

See indicator wording for requirement criteria.

MH indicator 011 (based on NM129)

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 who have pre-existing cardiovascular conditions, and/or smoke, and/or are overweight [BMI of ≥ 23 kg/m² or ≥ 25 kg/m² if ethnicity is recorded as White]) or preceding 24 months for all other patients.

MH 011.1 Rationale

A 2014 literature review that explored obesity and serious mental ill health, concluded that the use of antipsychotic medication may interfere with the normal processes which regulate food intake and metabolism.⁸³ Individuals with severe mental illness have five times the risk of dyslipidaemia compared to the general population.⁸⁴

MH 011.2 Reporting and verification

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.

MH indicator 012 (based on NM130)

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.

⁸⁰ 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.

⁸¹ 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.

⁸² Kessler RC, Rubiow DR, Holmes C et al. The epidemiology of DSM-III-R bipolar I disorder in a general population survey. *Psychological Medicine* 27: 1079-89. 1997.

⁸³ Bradshaw, T., & Mairs, H. (2014, June). Obesity and serious mental ill health: a critical review of the literature. In *Healthcare* (Vol. 2, No. 2, pp. 166-182). Multidisciplinary Digital Publishing Institute.

⁸⁴ <https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2019/03/nhs-rightcare-toolkit-cvd-prevention.pdf>

MH 012.1 Rationale

Diabetes is 2–3 times more common among people with SMI than the general population⁸⁵ and antipsychotic medication can be diabetogenic.⁸⁶ 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 SMI are more likely to develop type 1 diabetes later than those without a SMI, as late as the third and fourth decades of life.⁸⁷

MH 012.2 Reporting and verification

See indicator wording for requirement criteria.

Patients who have a diagnosis of diabetes will be excluded from this indicator.

Cancer (CAN)

Indicator	Points	Achievement 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	
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 (NICE 2020 menu ID: NM205)	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 been informed of the support available from primary care, within 3 months of diagnosis (based on NM204)	2	70-90%

⁸⁵ 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.

⁸⁶ 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.

⁸⁷ <https://bjgp.org/content/68/669/166#xref-ref-4-1>

CAN – rationale for inclusion of indicator set

It is recognised that the principal active management of cancers occurs in the secondary care setting. However, general practice often has a key role in the referral and 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.

The introduction of the new and updated indicators for cancer aims to increase the personalisation of cancer care and the timing of the cancer care review.

CAN indicator 001

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'

CAN 001.1 Rationale

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.

CAN 001.2 Reporting and verification

See indicator wording for requirement criteria.

CAN indicator 005 (based on NM204)

The percentage of patients with cancer, diagnosed within the preceding 12 months, who have had the opportunity for a discussion and been informed of the support available from primary care, within 3 months of diagnosis.

CAN 005.1 Rationale

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.

This indicator supports recommendations 1.1.1, 1.3.4 and 1.3.5 from NICE guideline CG138 Patient experience in adult NHS services.⁸⁸

CAN 005.2 Reporting and verification

See indicator wording for requirement criteria.

This indicator will only apply to patients who have received their diagnosis on or after 1 April 2021.

For the purposes of this indicator, the 12-month timeframe starts from the date of diagnosis irrespective of whether or not the diagnosis was made in primary care.

⁸⁸ <https://www.nice.org.uk/guidance/cg138/chapter/1-Guidance>

CAN indicator 004 (NICE menu 2020 ID: NM205)

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

CAN 004.1 Rationale

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 ongoing support and information requirements.

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 review should also consider the co-ordination of care between sectors. Practices should use Macmillan's national, integrated electronic CCR template within their 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.⁸⁹

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.

Macmillan also provides Top Tips on Cancer Care Reviews⁹⁰ 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. Top Tips on Late Effects, Fatigue, Anxiety, Nutrition and other common problems are also available.⁹¹ Further information on care following a cancer diagnosis and the potential role for primary care can be found on the Macmillan website.⁹²

CAN 004.2 Reporting and verification

See indicator wording for requirement criteria.

For the purposes of this indicator, the 12-month timeframe starts from the date of diagnosis irrespective of whether or not the diagnosis was made in primary care.

This indicator will not include patients whose latest unresolved cancer diagnosis was earlier than 1 January 2021 as these patients should have already been reviewed.

⁸⁹ <https://www.macmillan.org.uk/healthcare-professionals/innovation-in-cancer-care/personalised-care#reviews>

⁹⁰ https://cdn.macmillan.org.uk/dfsmedia/1a6f23537f7f4519bb0cf14c45b2a629/1808-source/primary-care-top-tips-effective-cancer-care-reviews?_ga=2.92648989.1434683822.1611837616-486138938.1610014495

⁹¹ https://www.macmillan.org.uk/healthcare-professionals/news-and-resources/guides#search-result-stories-and-media_q=top%20tips&search-result-news-and-resources_e=0

⁹² <https://www.macmillan.org.uk/about-us/health-professionals/resources/resources-for-gps.html>

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 12 months of diagnosis.

Chronic kidney disease (CKD)

Indicator	Points	Achievement 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) (NICE 2014 menu ID: NM83)	6	

CKD – rationale for inclusion of indicator set

NICE CG182 recommends classifying CKD using a combination of GFR and Albumin Creatinine Ratio (ACR) categories as G1 to G5, see description in Table 1.

In a cross-sectional point prevalence study⁹³ of over 130,000 adults in England the age standardised prevalence of people with an estimated GFR <60 ml/min/1.73 m² (CKD stages 3-5) was 8.5 per cent. Those with CKD were more likely to have hypertension, diabetes and CVD compared to people with GFR>60 ml/min/1.73 m², the prevalence of CKD rose with age and female gender. Limited data are available to provide an estimate of the overall population prevalence of CKD (diagnosed and undiagnosed). The available estimate suggests an overall prevalence of 13 per cent.



This disease area applies to patients with category G3a, G3b, G4 and G5 CKD (eGFR<60 mL/min/1.73 m² confirmed with at least two separate readings over a three month period).

Late presentation of patients with kidney failure increases morbidity, mortality and healthcare associated with costs. The total cost of CKD in England in 2009/10 was estimated as being circa £1.4 billion.⁹⁴

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.

⁹³ Stevens, P et al. CKD management in the UK: NEOERICA project results. *Kidney International*: 2007. 2 (1) 92-99

Table 1. Classification of CKD using GFR and ACR categories

GFR and ACR categories (including stages of CKD from previous guideline)			Albuminuria categories (mg/mmol)		
			<3 Normal to mildly increased	3-30 Moderately increased	>30 Severely increased
			A1	A2	A3
GFR categories (ml/min/1.73m ²)	290 Normal and high	G1 (stage 1)	No CKD*	G1 A2	G1 A3
	60-89 Mild reduction related to normal range for a young adult	G2 (stage 2)		G2 A2	G2 A3
	45-59 Mild- moderate reduction	G3a (stage 3a)	G3a A1 [^]	G3a A2	G3a A3
	30-44 Moderate- severe reduction	G3b (stage 3b)	G3b A1	G3b A2	G3b A3
	15-29 Severe reduction	G4 (stage 4)	G4 A1	G4 A2	G4 A3
	<15 Kidney failure	G5 (stage 5)	G5 A1	G5 A2	G5 A3
				 Increasing risk	
			 Increased risk		
<p>*By definition, in the absence of evidence of kidney damage, these categories are not CKD</p> <p>[^] Consider using eGFRcystatinC to confirm the diagnosis of CKD in people with eGFRcreatinine of 45-59 ml/min/1.73m², sustained for at least 90 days and no proteinuria (ACR less than 3 mg/mmol)</p>					

CKD indicator 005 (NICE 2014 menu ID: NM83)

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)

CKD 005.1 Rationale

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.

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 eGFR estimated.

CKD 005.2 Reporting and verification

See indicator wording for requirement criteria.

Epilepsy (EP)

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

EP – rationale for inclusion of indicator set

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 the QOF, epilepsy is defined as 'recurrent unprovoked seizures'.

EP indicator 001

The contractor establishes and maintains a register of patients aged 18 or over receiving drug treatment for epilepsy

EP 001.1 Rationale

The disease register includes patients aged 18 or over, as care for younger patients is generally undertaken outside of primary care.

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.

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.

EP 001.2 Reporting and verification

See indicator wording for requirement criteria.

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.

Learning disabilities (LD)

Indicator	Points	Achievement thresholds
Records		
LD004. The contractor establishes and maintains a register of patients with learning disabilities (NICE 2013 menu ID: NM73)	4	

LD – rationale for inclusion of indicator set

People with learning disabilities are among the most vulnerable and socially excluded in our society. It is estimated that there are approximately 20/1,000 people with mild learning disabilities and 3-4/1,000 with severe and profound learning disabilities in the UK. Over the past three decades, almost all the long-stay NHS beds for people with learning disabilities have closed and virtually all people with learning disabilities are now living in the community and depend on general practice for their primary care needs.

Care of patients with a learning disability is a quality improvement topic for 2021/22. This is detailed in Section 5.

LD indicator 004 (NICE 2015 menu ID: NM73)

The contractor establishes and maintains a register of patients with learning disabilities

LD 004.1 Rationale

This register indicator includes people of any age with a learning disability. This is because without a complete register of people with learning disabilities, practices may not be aware of the reasonable adjustments that may be needed for a child or young person with learning disabilities and their family, and of the help and support that may be useful to them. Evidence suggests there are an increasing number of children with learning disabilities now surviving childhood, some of whom will have profound and multiple disabilities as they grow up.⁹⁵ It also suggests that health services are often unprepared for these children and young people and the complexity of their problems.⁹⁶

A full register of patients with learning disabilities will provide primary care practitioners with the first important building block in providing better quality and more appropriate services for this patient population.

⁹⁵ 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>

⁹⁶ 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

Learning disabilities are heterogeneous conditions, but are defined by three core criteria:

- 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;
- significant impairment of social or adaptive functioning; and
- onset in childhood.

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.

NHS England has published guidance⁹⁷ aimed at improving the identification of people with a learning disability. Practices should review this guidance and update their registers on a regular basis to ensure that they are accurate. 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 policies, procedures, staff training and service delivery to ensure that they work equally well for people with learning disabilities.⁹⁸

LD 004.2 Reporting and verification

See indicator wording for requirement criteria.

There was a significant revision of the clinical codes used to create this register in 2019. Full details are available in the Business Rules and coding guidance published in 2019.

⁹⁷ 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>

⁹⁸ PHE. Making reasonable adjustments to eye care services for people with learning disabilities. 2013. <http://www.improvinghealthandlives.org.uk/publications.php5?rid=1167&edit>

Osteoporosis: secondary prevention of fragility fractures (OST)

Indicator	Points	Achievement 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 (NICE 2011 menu ID: NM29)	3	

OST – rationale for inclusion of indicator set

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.

Interventions for secondary prevention of fractures in patients who have had an osteoporotic fragility fracture include pharmacological intervention.

OST indicator 004 (NICE 2011 menu ID: NM29)

The contractor establishes and maintains a register of patients:

- 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
- Aged 75 or over with a record of a fragility fracture on or after 1 April 2014 and a diagnosis of osteoporosis.

OST 004.1 Rationale

Fragility fractures are fractures that result from low-level trauma, which means mechanical forces that would not ordinarily cause fracture. The WHO has 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.^{99 100}

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-

⁹⁹ WHO. Guidelines for preclinical evaluation and clinical trials in osteoporosis. 1998.

¹⁰⁰ NICE CG146. Osteoporosis: assessing the risk of fragility fracture. 2017.

<http://www.nice.org.uk/guidance/CG146>

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.

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 unfeasible.¹⁰¹ The SIGN guideline on the management of osteoporosis¹⁰² 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.

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.

In women, the prevalence of osteoporosis increases markedly with age after menopause, 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 postmenopausal 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 are an estimated 180,000 new fragility fractures in postmenopausal women in the UK each year; three quarters in women aged 65 or over.

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.

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.

The SIGN guideline recommends that patients who have suffered one or more fragility fractures are priority targets for investigation and treatment of osteoporosis.

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.

¹⁰¹ NICE technology appraisal TA161. Alendronate, etidronate, risedronate, raloxifene, strontium ranelate and teriparatide for the secondary prevention of osteoporotic fragility fractures in postmenopausal women. 2017. <http://www.nice.org.uk/guidance/TA161>

¹⁰² SIGN guideline 142. Management of osteoporosis and the prevention of fragility fractures. 2015. <https://www.sign.ac.uk/media/1741/sign142.pdf>

OST 004.2 Reporting and verification

The Business Rules for the two-part register will look for the following criteria:

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).

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).

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.

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).

Patients with fragility fractures sustained in the last three months of the year will be excepted from this indicator.

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.

Rheumatoid arthritis (RA)

Indicator	Points	Achievement thresholds
Records		
RA001. The contractor establishes and maintains a register of patients aged 16 or over with rheumatoid arthritis (NICE 2012 menu ID: NM55)	1	
Ongoing management		
RA002. The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 12 months (NICE 2012 menu ID: NM58)	5	40–90%

RA – rationale for inclusion of indicator set

Rheumatoid arthritis (RA) is a chronic, disabling auto-immune disease characterised by inflammation in the peripheral joints, which 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.

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 on the person's life, for example side effects to medication and whether they would benefit from any referrals to the MDT.

RA indicator 001 (NICE 2012 menu ID: NM55)

The contractor establishes and maintains a register of patients aged 16 or over with rheumatoid arthritis

RA 001.1 Rationale

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.

The register is restricted to patients aged 16 or over, to conform to international standards for differentiating RA from juvenile idiopathic arthritis.

The register also includes patients with inactive RA. There are three potential groups of patients whose disease may be referred to as inactive:

- patients who are being treated and whose disease is in remission
- patients who are not receiving treatment for RA but have evidence of past disease, i.e. joint deformities. This type of RA is sometimes known as 'burnt out' RA. These patients are on the register as they remain at risk of the systemic effects of RA
- patients who are not receiving treatment for RA who have no evidence of past disease but there is doubt about their diagnosis. The contractor may wish to request (ESR) or plasma viscosity, C-reactive protein (CRP), rheumatoid factor and hand X-ray to determine the accuracy of the diagnosis. Inaccurate diagnoses can be removed from the patient's patient record which would also remove them from the register.

Recognition of synovitis in primary care and prompt referral for specialist advice 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.

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 NG100¹⁰³ recommends that patients with persistent synovitis are referred for specialist opinion. Urgent referral is needed when any of the following are present:

- the small joints of the hands or feet are affected
- more than one joint is affected
- there has been a delay of three months or longer between the onset of symptoms and seeking medical advice.

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.

RA 001.2 Reporting and verification

See indicator wording for requirement criteria.

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.

RA indicator 002 (NICE 2012 menu ID: NM58)

The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 12 months

RA 002.1 Rationale

RA is a chronic disease with a variable course over a long period of time. Therefore, there is a need for regular monitoring to determine disease status, assess severity, efficacy and toxicity of drug therapy and identify co-morbidities or complications.

Patients with satisfactorily controlled established disease require review appointments for ongoing drug monitoring, additional visits for disease flares and rapid access to specialist care. RA and its treatment can also have a negative effect on a patient's quality of life. It is recommended that contractors review the following aspects of care with a patient:

- disease activity and damage, which may include requesting C-reactive protein (CRP) or erythrocyte sedimentation rate (ESR) or plasma viscosity test
- a discussion of DMARDs, if relevant
- the need for referral for surgery
- the effect the disease is having on their life, for example employment or education
- the need to organise appropriate cross-referral within the MDT.

As a minimum, it is advised that this review covers disease activity and damage, the effect of the disease on the patient's life and whether they would benefit from any referrals to the MDT.

¹⁰³ NICE NG100. Rheumatoid arthritis in adults: management. 2018
<https://www.nice.org.uk/guidance/ng100>

RA 002.2 Reporting and verification

See indicator wording for requirement criteria.

Verification – Commissioners may wish to review patient records to ensure that all essential elements of the review have been performed.

Palliative care (PC)

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

PC – rationale for inclusion of indicator set

Palliative or end of life care is the active total care of patients with life-limiting disease and their families by a multi-professional team. The first National End of Life Care (EoLC) Strategy¹⁰⁴ was published in July 2008 followed by:

- the National Palliative and EoLC Partnership. Ambitions for palliative and EoLC: A national framework for local action 2015-2020. <http://endoflifecareambitions.org.uk/wp-content/uploads/2015/09/Ambitions-for-Palliative-and-End-of-Life-Care.pdf>
- DH. Our commitment to you for EoLC: The Government response to the review of choice in EoLC. 2016. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/536326/choice-response.pdf

Supporting patients to make personalised end of life care plans is a key commitment in the NHS Long Term Plan.¹⁰⁵ There is also a commitment to improve access to palliative and end of life care for children. Timely identification of people in need of this support will be key to making these quality improvements.

PC indicator 001

The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age

PC 001.1 Rationale

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. A quarter of all deaths are due to cancer, a third from organ failure, a third from frailty or dementia and only one twelfth of patients have a sudden death. It may therefore be possible to predict the majority of deaths; however, this is difficult and errors occur 30 per cent of the time. Two thirds of errors are based on over optimism and one third on pessimism. However,

¹⁰⁴ DH. National EoLC strategy. 2008. <https://www.gov.uk/government/publications/end-of-life-care-strategy-promoting-high-quality-care-for-adults-at-the-end-of-their-life>

¹⁰⁵ NHS England. The NHS Long Term Plan. 2019. <https://www.longtermplan.nhs.uk>

the considerable benefits of identifying these patients include providing the best health and social care to both patients and families and avoiding crises, by prioritising them, anticipating need and enabling patients to be able to make informed decisions about the care and support they need.

Identifying patients in need of palliative care, **assessing** their needs and preferences and proactively **planning** their care, are the key steps in the provision of high quality care at the end of life 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.¹⁰⁶

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)
- they are entitled to a DS 1500 form (the DS 1500 form is designed to speed up the payment of financial benefits and can be issued when a patient is considered to be approaching the terminal stage of their illness. For these purposes, a patient is considered as terminally ill if they are suffering from a progressive disease and are not expected to live longer than six months).

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 it enables the wider practice team to provide more appropriate and patient focussed care.

PC 001.2 Reporting and verification

See indicator wording for requirement criteria.

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

¹⁰⁶ 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>

Non diabetic hyperglycaemia (NDH)

Indicator	Points	Achievement thresholds
Records		
NDH001. The percentage of patients with non-diabetic hyperglycaemia who have had an HbA1c or fasting blood glucose performed in the preceding 12 months (NICE 2017 menu ID: NM150)	18	50–90%

NDH – rationale for inclusion of indicator set

NDH is defined as an HbA1c on 42-47mmol/mol or a fasting plasma glucose (FPG) of 5.5-6.9mmol/l. There were 1.8 million people with NDH in England in July 2018.

The NHS has invested heavily 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 230,000 people have already benefited since its introduction in 2016. It has proven effective at causing weight loss and reducing HbA1c.¹⁰⁷

NDH indicator 001 (NICE 2017 menu ID: NM150)

The percentage of patients with non-diabetic hyperglycaemia who have had an HbA1c or fasting blood glucose performed in the preceding 12 months

NDH 001.1 Rationale

NICE Guidance (PH38¹⁰⁸) recommends that everyone with NDH is offered an annual blood test to check for progression to Type 2 diabetes and indicators are available on the NICE menu to support this activity. Despite this there is wide variation in the monitoring of people with NDH.

The aim of this indicator is to promote early identification of when people cross the threshold into the type 2 diabetes category, as it is associated with reduced CVD event rate and lower mortality in the individuals identified. Criteria for diagnosing diabetes are discussed in the diabetes section of this guidance.

NDH 001.2 Reporting and verification

See indicator wording for requirement criteria.

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

¹⁰⁷ Diabetologia 2019; 62 (Suppl.1): S89

¹⁰⁸ NICE guidance PH38: Type 2 diabetes: prevention in people at high risk
<https://www.nice.org.uk/guidance/ph38>

Section 4: Public Health domain

Blood pressure (BP)

Indicator	Points	Achievement thresholds
BP002. The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years <i>(based on NM61)</i>	15	50–90%

BP indicator 002 (based on NM61)

The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years

BP 002.1 Rationale

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 hypertension¹⁰⁹ are to be followed by practitioners when deciding on whether to treat raised blood pressure.

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.

It is anticipated that contractors will opportunistically check blood pressures in all adult patients.

BP 002.2 Reporting and verification

See indicator wording for requirement criteria.

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.

¹⁰⁹ NICE CG136. Hypertension in adults: diagnosis and management. 2019.
<http://www.nice.org.uk/guidance/cg136>

Obesity (OB)

Indicator	Points	Achievement thresholds
Records		
OB002. The contractor establishes and maintains a register of patients aged 18 years or over with a BMI ≥ 30 in the preceding 12 months (based on NM143)	8	

OB – rationale for inclusion of indicator set

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 use.¹¹⁰ Nearly two-thirds of adults in England are overweight or obese, some of the worst figures in Europe.¹¹¹ 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.

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 , amongst other actions to reduce obesity.

Further information

NICE has produced multiple guidelines on clinical and public health approaches to tackling obesity, they can be accessed via the NICE Obesity Pathway <https://pathways.nice.org.uk/pathways/obesity>

OB indicator 002

The contractor establishes and maintains a register of patients aged 18 years or over with a BMI ≥ 30 in the preceding 12 months

OB 002.1 Rationale

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.

NICE guideline CG189¹¹² 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.

¹¹⁰ 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)

¹¹¹ OECD. Obesity update 2017. Available from <http://www.oecd.org/health/obesity-update.htm>

¹¹² NICE CG189. Obesity. 2014. <https://www.nice.org.uk/guidance/cg189>

OB 002.2 Reporting and verification

See indicator wording for requirement criteria.

Smoking (SMOK)

Indicator	Points	Achievement 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 (NICE 2011 menu ID: NM38)	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 (based on NM40)	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 (NICE 2011 menu ID: NM39)	25	56–96%

SMOK – rationale for inclusion of indicator set

Smoking has been identified as one of the top five risk factors for premature death in England. In England, 10% of pregnant women were known to be smokers at the time of delivery.¹¹³ 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 degeneration and periodontitis.¹¹⁴ 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

¹¹³ NHS Digital. Statistics on Women's Smoking Status at Time of Delivery: England Quarter 2, 2020-21: <https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-women-s-smoking-status-at-time-of-delivery-england/statistics-on-womens-smoking-status-at-time-of-delivery-englandquarter-2-2020-21>

¹¹⁴ US DH and Human Services 2004

sudden unexpected death in infancy.¹¹⁵ Smoking during pregnancy also increases the risk of infant mortality by an estimated 40 per cent.¹¹⁶

The aim of this domain is to increase the proportion of successful smoking quit attempts by providing the best available support and 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.

'An offer of support and treatment' means offering a referral or self-referral to a local NHS Stop Smoking Service adviser (who might be a member of the practice team) plus pharmacotherapy. Where such support 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.

The NICE guidance on smoking interventions and services¹¹⁷ identifies the evidence-based interventions available for adults who smoke:

- behavioural support (individual and group)
- bupropion¹¹⁸
- nicotine replacement therapy (NRT) – short and long acting
- varenicline¹¹⁹
- very brief advice.

For people who smoke and who are using, or are interested in using, a nicotine-containing e-cigarette 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
- many people have found them helpful to quit smoking cigarettes
- people using e-cigarettes should stop smoking tobacco completely, because any smoking is harmful
- the evidence suggests that e-cigarettes are substantially less harmful to health than smoking but are not risk free
- the evidence in this area is still developing, including evidence on the long-term health impact.

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.

¹¹⁵ NICE PH26. Smoking: stopping in pregnancy and after childbirth. 2010.
<http://www.nice.org.uk/guidance/ph26>

¹¹⁶ DH. Review of the health inequalities infant mortality PSA target. 2007.
<http://www.perinatal.nhs.uk/smoking/Health%20Inequalities%20report%202007.pdf>

¹¹⁷ NICE NG92. Stop smoking interventions and services. 2018.
<https://www.nice.org.uk/guidance/ng92>

¹¹⁸ See information on [bupropion hydrochloride](#) in the British national formulary.

¹¹⁹ See information on [varenicline](#) in the British national formulary.

For further information

NICE public health guidance 45. Smoking: harm reduction. 2013.
<https://www.nice.org.uk/guidance/ph45>

NICE public health guidance 48. Smoking: acute, maternity and mental health services. 2013. <https://www.nice.org.uk/guidance/ph48>

SMOK indicator 002 (NICE menu 2011 ID: NM38)

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

SMOK 002.1 Rationale

See rationale above.

SMOK 002.2 Reporting and verification

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

Smokers

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

Non-smokers

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 for until the end of the financial year in which the patient reaches the age of 25.

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).

Ex-smokers

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.

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.

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.

SMOK indicator 004 (based on NM40)

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

SMOK 004.1 Rationale

See rationale above.

SMOK 004.2 Reporting and verification

See indicator wording for requirement criteria.

There is no APDF calculation for SMOK004.

SMOK indicator 005 (NICE 2011 menu ID: NM39)

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

SMOK 005.1 Rationale

See rationale above for guidance on 'support and treatment' and smoking cessation.

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.

SMOK 005.2 Reporting and verification

See indicator wording for requirement criteria.

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.

Vaccination and Immunisations (VI)

Indicator	Points	Achievement thresholds	Points at lower threshold
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 (NICE 2020 menu ID: NM197)	18	90-95%	3
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 (NICE 2020 menu ID: NM198)	18	90-95%	7
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 (NICE 2020 menu ID: NM199)	18	87-95%	7
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 (based on NM201)	10	50-60%	-

VI – rationale for inclusion of indicator set

Vaccination currently prevents 2-3 million deaths worldwide every year.¹²⁰ 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 vaccines.¹²¹

VI indicator 001 (NICE 2020 menu ID: NM197)

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.

¹²⁰ <https://www.who.int/en/news-room/fact-sheets/detail/immunization-coverage>

¹²¹ <https://www.who.int/news-room/spotlight/ten-threats-to-global-health-in-2019>

VI 001.1 Rationale

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).

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.

VI 001.2 Reporting and verification

See indicator wording for requirement criteria.

The only personalised care adjustment applicable is where the intervention described in the indicator is contraindicated for the patient.

NM indicator 002 (NICE 2020 menu ID: NM198)

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.

VI 002.1 Rationale

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](#)).

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.

VI 002.2 Reporting and verification

See indicator wording for requirement criteria.

The only personalised care adjustment applicable is where the intervention described in the indicator is contraindicated for the patient.

VI indicator 003 (NICE 2020 menu ID: NM199)

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.

VI 003.1 Rationale

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.

VI 003.2 Reporting and verification

See indicator wording for requirement criteria.

The only personalised care adjustment applicable is where the intervention described in the indicator is contraindicated for the patient.

VI indicator 004 (based on NM201)

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.

VI 004.1 Rationale

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.

The indicator supports vaccination against shingles for patients aged 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.

VI 400.2 Reporting and verification

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

Cervical screening (CS)

Indicator	Points	Achievement 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 (NICE 2017 menu ID: NM154)	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 (NICE 2017 menu ID: NM155)	4	45-80%

CS indicator 005 (NICE 2017 menu ID: NM154)

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

CS indicator 006 (NICE 2017 menu ID: NM155)

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

CS005.1 and 006.1 Rationale

These indicators are designed to encourage and incentivise contractors to offer age appropriate cervical screening in line with the recommendations of the NHS Screening Programme and to continue to achieve high levels of uptake of this.

Specific requirements apply to these indicators in relation to the Personalised Care Adjustment. These are detailed in Section 6.

CS005.2 and CS006.2 Reporting and verification

See indicator wording for requirement criteria.

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.

Women 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. Since 2019, there is a discrete SNOMED code to record that women have not responded to three invitations for cervical screening.

Section 5: Quality Improvement domain

Early cancer diagnosis

Indicator	Points	Achievement thresholds
QIECD005. The contractor can demonstrate continuous quality improvement activity focused on early cancer diagnosis as specified in the QOF guidance	27	NA
QIECD006. The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity focused on early cancer diagnosis as specified in the QOF guidance. This would usually include participating in a minimum of two peer review meetings	10	NA

Care of people with learning disabilities

Indicator	Points	Achievement thresholds
QILD007. The contractor can demonstrate continuous quality improvement activity focused on care of patients with a learning disability as specified in the QOF guidance	27	NA
QILD008. The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity focused on the care of patients with a learning disability as specified in the QOF guidance. This would usually include participating in a minimum of two network peer review meetings	10	NA

Rationale for inclusion of a QI domain

The aim of this domain is to provide support for contractors and their staff to recognise areas of care which require improvement, and take steps to address this through the development and implementation of a quality improvement plan and sharing of learning across their network. Being skilled in quality improvement has been recognised as a key role for healthcare professionals in the Shared View of Quality.¹²²

NHS England and GPC England have worked with the Royal College of General Practitioners, NICE and the Health Foundation to develop the topic specific guidance included here. This guidance sets specific objectives for each topic which contractors are expected to work towards and provides advice on potential quality improvement actions. Within the parameters set out in this guidance, contractors are encouraged to understand where they have the potential to make quality improvements and then to design and implement bespoke quality improvement plans, including improvement

¹²² <https://www.england.nhs.uk/wp-content/uploads/2016/12/nqb-shared-commitment-frmwrk.pdf>

targets to address these. There are no deadlines given for the completion of the diagnostic activities, the subsequent plan or the network meetings. However, contractors are advised that they are expected to be working on these improvement activities throughout the QOF year.

The two topic areas for 2021/22 are early diagnosis of cancer and supporting people with learning disabilities. For 2021/22 these modules will be repeated in their original format, with some slight modifications to account for the impact of the pandemic on care.

Following 2021/22, the QI topics will change on an annual basis. Through practice engagement with these and future modules we expect to see measurable improvement in the quality of care and patient experience at a national level against the areas of focus described in the individual modules.

The focus of the indicators and associated points is on contractor engagement and participation in the quality improvement activity both in the practice and through sharing of learning across their network. This is to recognise that not all quality improvement activity will be successful in terms of its immediate impact on patient care. If a contractor does not achieve the targets which they have set themselves this would not in itself be a reason to withhold QOF points and associated payments, unless they have also failed to participate in the activities described in the guidance.

All the supporting information and resources referred to in this guidance will be made available on NHS England's website by end of March 2021. Further information as to how to undertake quality improvement activities is available from a number of sources including:

NHS England Sustainable Improvement Team

(<https://www.england.nhs.uk/sustainableimprovement/>) - this is a national resource to support quality improvement activity in primary care and includes training, practical advice and support from quality improvement specialists.

NHS Improvement (<https://improvement.nhs.uk/improvement-hub/>) - resources including improvement tools and case studies.

RCGP QI resources (www.rcgp.org.uk/qi) - resources including the RCGP QI Guide for General Practice and other quick guides to the use of quality improvement tools and techniques. These are available to both members and non-members.

Health Foundation (<https://www.health.org.uk/publications/quality-improvement-made-simple>) - an easy to read and practical guide to undertaking QI

NICE Practical Steps (<https://intopractice.nice.org.uk/practical-steps-improving-quality-of-care-services-using-nice-guidance/index.html>) – online guide to putting NICE guidance into practice and tools to support this.

Institute for Health Improvement (<http://www.ihl.org/>) – a US site with a range of resources to support QI activity.

Early cancer diagnosis

Indicator	Points	Achievement thresholds
QIECD005. The contractor can demonstrate continuous quality improvement activity focused on early cancer diagnosis as specified in the QOF guidance	27	NA
QIECD006. The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity focused on early cancer diagnosis as specified in the QOF guidance. This would usually include participating in a minimum of two peer review meetings	10	NA

Rationale

Cancer has a huge impact both in numbers of people affected and on the individual and those close to them. More than 300,000 people received a first treatment for cancer in the UK in 2018 ([NHS England 2019](#)). Although cancer outcomes have improved significantly with 10,000 more patients surviving for at least 12 months after diagnosis than compared with five years earlier ([NHS England 2019](#)), international studies have demonstrated that the UK can make further improvements.

[The NHS Long Term Plan](#) sets out an ambition that by 2028 the proportion of cancers diagnosed at stages 1 and 2 will rise from around half now to three-quarters of cancer patients. NHS England estimates that achieving this will mean that, from 2028, 55,000 more people each year will survive their cancer for at least five years after diagnosis.

For most cancers survival is much greater at both one and five years if detected at stage one – highlighting the need for early diagnosis ([Hawkes 2019](#)). Other benefits from early diagnosis include relief of symptoms ([NICE 2017](#)).

In 2020/21 the coronavirus pandemic presented major challenges for all healthcare systems. One of the most significant impacts was a sharp reduction in the number of people coming forward to general practice and being referred urgently with suspected cancer and referred from cancer screening programmes. Thanks to the efforts of NHS staff and their partners, the number of people receiving first or subsequent treatment was maintained at % of that in the same period in 2019 (March to December 2020). Although urgent cancer referrals recovered in late 2020, it will be important to avoid a repeat of the steep fall in referrals we saw in April 2020.

It is important therefore for practitioners to retain a high index of suspicion, to continue to refer patients in line with NG12 and to safety net patients with suspected cancer. Practices should maintain an awareness of referral and testing pathways,

including the impact of any pathway changes implemented as part of the pandemic response.

Furthermore, referral numbers have been slower to recover on some pathways than others – in particular on the lung and urology pathways – and the overall volume of people receiving first treatment for cancer in-year was down compared to the previous year. In light of this, it will be especially important for general practice to be vigilant in identifying potential cancer cases in 2021/22 so that as many of those people as possible who have not yet come forward can be picked up and referred at the earliest possible stage.

General practice plays a crucial role in the timely diagnosis of cancer, with almost 68% of people with cancer first reporting their symptoms at their GP surgery ([Swann et al 2018](#)). In the wake of the coronavirus pandemic it is important that practices continue to lead efforts to grow public confidence in the safety and availability of general practice services, including the availability of face-to-face consultations where required. Use of the NICE guideline on suspected cancer ([NG12](#)) may increase appropriate referrals for suspected cancer and reduce the number of presentations before referral ([NICE 2018](#)).

In addition, whilst other providers deliver screening services for bowel and breast cancer, actions taken in general practice can increase uptake of national cancer screening programmes ([Hewitson et al 2011](#)). Cancer screening programmes have been shown to improve patient outcomes:

- Regular bowel cancer screening has been shown to reduce the risk of dying from bowel cancer by over 16% ([UK NSC 2018](#)).
- Deaths from cervical cancer have decreased by around 60% since the introduction of the national cervical screening programme ([UK NSC 2015](#)).
- Evidence suggests a 20% reduction in deaths from breast cancer in women invited for breast screening ([UK NSC 2013](#)).

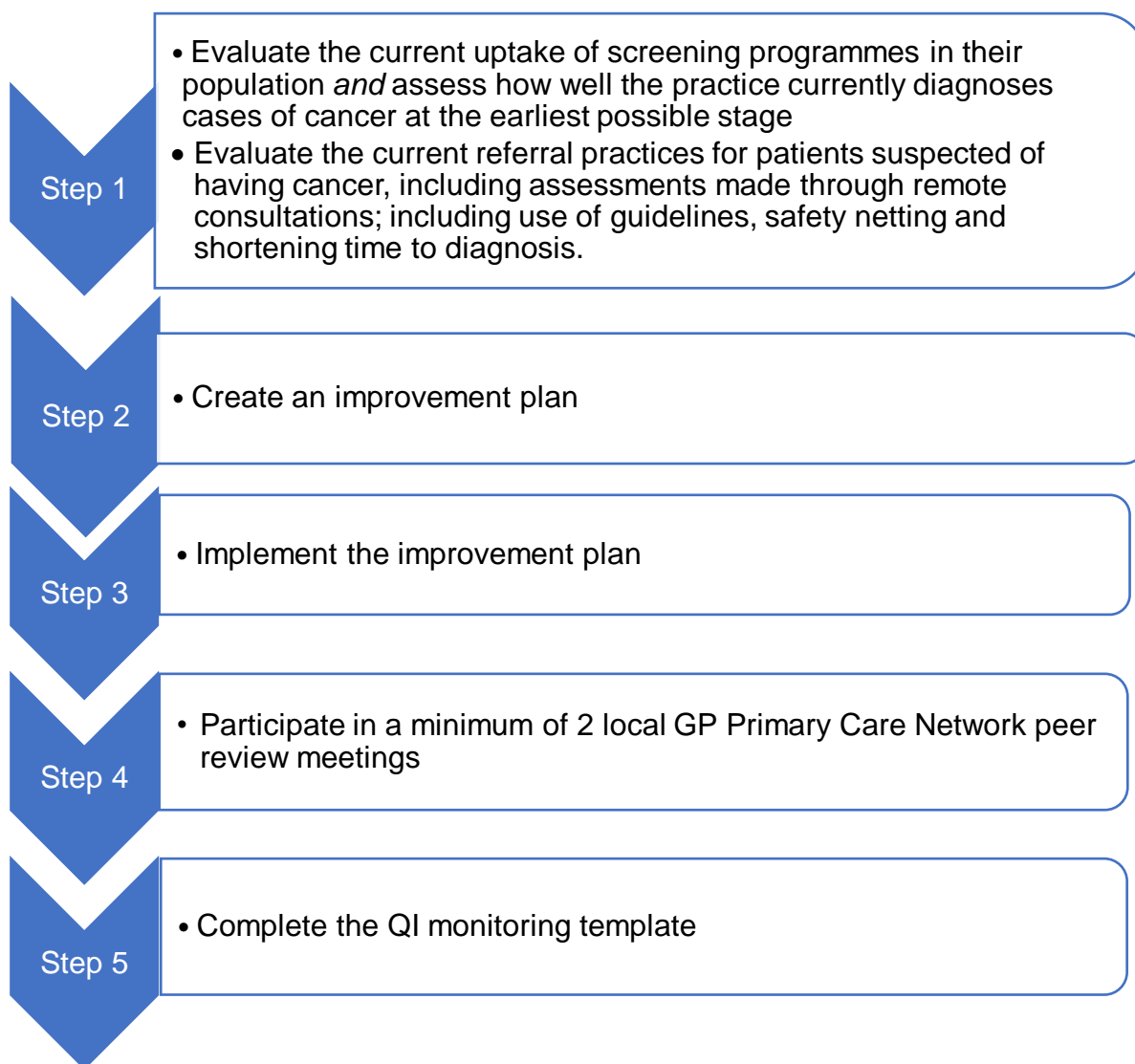
[The NHS Long Term Plan](#) sets out an ambition that by 2028 the proportion of cancers diagnosed at stages 1 and 2 will rise from around half now to three-quarters of cancer patients. NHS England estimate that achieving this will mean that, from 2028, 55,000 more people each year will survive their cancer for at least five years after diagnosis.

Overview of the QI module

The overarching objective of these QI indicators is to contribute to improvements in relation to the following aspects of care:

- 1) Participation in national breast, cervical and bowel cancer detection and prevention screening programmes among a practice's registered population.
- 2) Referral practices for patients suspected of having cancer; including use of guidelines, professional development, safety netting of those referred on suspected cancer pathways and shortening of diagnostic intervals.

Practices will need to undertake the following steps:



The following section includes further detail on the types of things practices could do to deliver this module. These are suggestions and recommendations only and the decision about what to include in the QI plan and which QI methodologies to use should be made by practices and shared with their peers through the network meetings.

Practices are expected to undertake quality improvement activity in *both* screening and early diagnosis. This quality improvement activity will support existing efforts of local public health commissioning teams and Cancer Alliances and will contribute to the success of STP and NHS Long Term Plan commitments.

Detailed contractor guidance

1. Identifying areas for improvement

All practices should start with an assessment of the current quality of care they provide. This should include:

1. An assessment of practice screening programme uptake rates compared to local or national baselines. [PHE fingertips](#) has an easy to use tool to compare cancer indicators by practice to quickly identify areas for more in-depth audits. Practices should consider how they can include a focus on inequalities in screening in their assessment, particularly for those at risk and with low uptake.
2. An assessment of current referral practice through:
 - i. Participation in the National Cancer Diagnosis Audit or other retrospective audit of recent cancer diagnoses. Data could be collected, e.g. on the route to diagnosis; referral pathways used; use of virtual vs face-to-face appointments; time from first presentation of symptoms/signs in primary care to referral and investigations. Practices can use their existing 2019/20 NCDA audit report. Practices may want to focus in more depth on cancers such as lung where there is often more unmet need and where, as a result of the pandemic, there has been a significant drop in the number of urgent cancer referrals and subsequent number of first treatments. All tumour types have seen a drop in the number of first treatments; however, those where there has been the most significant decrease include the other most common cancers – breast, colorectal and prostate – as well as skin, bladder, head and neck, kidney and uterine. Practices may find the Quality Improvement Toolkit for Early Diagnosis of Cancer helpful in identifying ways to use their audit findings to inform their quality improvement activity. <https://www.rcgp.org.uk/cancer>
 - ii. From the patients identified in the audit, practices may find it helpful to undertake a more in-depth learning / significant event analysis around a patient where the referral or diagnosis process could have been better as a way to further identify areas for quality improvement. The RCGP and Macmillan have a helpful toolkit for this type of analysis www.rcgp.org.uk/seatoolkit

Practices could also, or alternatively, audit and review the current system in place for safety netting around suspected cancer diagnoses as their early diagnosis activity. Practices who do not have a demonstrably robust practice-wide system for safety netting suspected cancer patients should consider implementing one as part of their quality improvement activities. [Macmillan's safety netting and coding module](#) could support this activity and the Macmillan Quality Improvement Toolkit can also provide some structure to improve this area (Module 2, question 8).

It is anticipated that practice QI activity will dovetail with both local priorities and wider cancer activities. The work is intended to align with existing efforts of local public health commissioning teams and cancer alliances. GP network peer group meetings will provide a forum to establish and agree on allied priorities.

Practices are encouraged to seek the views of patients and carers where this will help with quality improvement activity. This could be done through engagement with a patient participation group and/ or a survey of patients.

Practices may also find it useful to undertake a reflective group meeting and complete a 'SWOT' (strengths, weaknesses, opportunities and threats) analysis. Guidance as to how to do this can be found in the RCGP guide [How to get started in QI](#).

2. Creating an improvement plan

Following the diagnostic phase above, practices should focus their QI activities on outcomes such as:

1. An increase in the follow-up and informed consent/refusal of screening for cervical, breast or bowel cancer.
2. A reduction in inequitable uptake of screening in population groups identified by the practice.
3. An increase in the proportion of cases where cancer diagnoses are reviewed and learnt from.
4. A decrease in the time from presentation to referral.
5. An increase in the proportion of suspected cancer referrals where a demonstrably robust practice-wide system for safety-netting is used.

These outcomes will be used at a national level to assess the impact of the module and practices should consider how they measure improvement when choosing aims for their projects. *The above have been designed as process-based measures as the time lag for national screening and diagnosis outcome data is too long to assess in a year of improvement.*

Practices may wish to use both data collected during the National Cancer Diagnosis Audit and the ensuing bespoke improvement report provided (by the NCDA) as aids to identify change ideas. Macmillan's Quality Improvement Toolkit for Cancer Care in Primary Care also includes searches that have been integrated into the three main GP IT systems (EMIS Web, TPP SystemOne, INPS Vision) within England to support the identification of areas for quality improvement around screening and early diagnosis.

Once practices have identified their area/s for improvement they should be clear about:

- **The aims** of the project – what will be achieved and by when. These aims should be SMART (specific, measurable, achievable, relevant, and time-bound).
- **The measures** – what data will be collected to know if the aims have been met. Measurements to assess the effectiveness of changes made should be straightforward for teams to collect regularly. Practice project measures could be stratified into:
 - Process, e.g. proportion of patients screened for x cancer
 - Outcomes, e.g. level of confidence of a team member to opportunistically raise screening at reception (then book a smear appointment)

- Balancing, e.g. the average waiting time for a routine appointment (at the expense of extra smear clinics)
- **The changes** – what different ways of doing things will be tested.

Practices should choose their own quality improvement activities and set their own targets for improvement based on their baseline audit or search results. These should be challenging but realistic and recognise that it may be easier to make larger improvements when starting from a modest baseline. These should be validated by network peers as part of the initial network review meeting. Multiple small tests of change are recommended. Practices should aim to find a way to ensure improvement is continuous and that quality improvement around early cancer diagnosis becomes routine. See Box 1 for examples of SMART aims.

Box 1. Examples of SMART aims

Area for improvement 1: Baseline analysis identifies x% of people eligible for screening for y cancer have not responded to invites.

SMART aim: The practice aims to contact z% of non-responders over the next 6 months providing additional information to support informed decision making about screening.

Area for improvement 2: Baseline analysis identifies only x% of eligible patients with a learning disability have responded to their screening invite.

SMART aim: The practice aims to contact y% of non-responders with a learning disability over 6 months and provide appropriate support to make informed decisions or best interest decisions as appropriate.

Area for improvement 3: Baseline analysis identifies only x% of new cancer diagnosis cases are reviewed and learnt from.

SMART aim: The practice aims to increase the % of new cancer diagnosis cases which are reviewed and learnt from, by y% to z%, over 6 months.

Area for improvement 4: Baseline analysis identifies an average of x days from initial presentation to date of referral.

SMART aim: The practice aims to decrease the time from initial presentation to referral to under y days over the next 6 months. *(This may not be an ideal choice for smaller practices or where high-quality audit data is not available)*

Area for improvement 5: Baseline analysis identifies the proportion of suspected cancer referrals with systematic safety netting to check they are seen in secondary care as x%.

SMART aim: The practice aims to increase the proportion of referrals with systematic safety netting to y% over the next 6 months.

iii. Implementing the plan

Practices should implement the improvement plan they have developed to support the objectives they have identified. It is recommended that these plans and associated improvement activities should involve the whole practice team and practices are encouraged to engage with colleagues outside the practice where practical, for example public health and the screening service if addressing screening, or secondary care or other local practices when addressing early diagnosis in order to share learning.

Where possible, patients should be involved in quality improvement activity, at the most basic level this would involve discussion of planned activity with the practice's patient participation group but could involve surveys and or focus groups where this would be practical and relevant for the planned activity.

Example case studies can be downloaded from <https://www.england.nhs.uk/wp-content/uploads/2020/02/20-21-qof-qi-cases-studies.pdf>

iv. Network peer review meetings

A key objective of the network peer review meetings is to enable shared learning across the network. The first meeting should aim to validate and agree meaningful QI activity plans and to share baseline information. The second should focus on shared learning from the quality improvement process and change activities undertaken. It is also intended to provide a forum for practices to identify wider system issues impacting on care quality which may require a collective response.

Whilst these meetings would usually be face to face, networks are able to explore other mechanisms to facilitate real time peer learning and sharing including virtual meetings. Practices can choose the most appropriate members of the team to attend. The peer review group will usually be the Primary Care Network of which the practice is a member. Suggested discussion points for these meetings are made in Box 2. The network clinical director or their nominated deputy or a clinical lead should facilitate these meetings and maintain a record of attendance. It is for the network to determine the timing of these meetings, but it is recommended that the first meeting takes place early in the QI activity at the stage of deciding on what quality improvement activities to undertake and the second towards the end to share outcomes and learning from these activities.

Contractors should participate in a minimum of two network peer review discussions unless there are exceptional and unforeseen circumstances which impact on a contractor's ability to participate, more meetings maybe beneficial to the process.

Box 2. Suggested peer review meeting discussion points

The **first** peer review meeting should take place early in the QI activity and focus on:

- Sharing the outputs of the audit and search baseline work to understand the issues for each practice, compare screening rates and share significant event analyses. Accounting for outlier practices, QI focus should ideally be on worst uptake of screening programmes at network/ 'local' level.
- Validation of practice improvement plans and targets.
- Alignment with the wider cancer activities and local priorities

Discussion points could include:

- What relevant evidence-based guidance / quality standards can the group use?
- What data has each practice used to inform its review of current performance? How timely and robust is this data?
- Has the right focus been chosen by each practice based on their current performance?
- Has each practice set a clear aim with a challenging but realistic local target, and agreed an appropriate measurement to monitor impact?
- What ideas for changes is each practice planning to try in an improvement cycle?
- How are practices ensuring that the whole practice team (including other clinical colleagues and patients and carers) are engaged in the proposed QI activity?
- The awareness and adoption of referral support technology to reduce variability, e.g. 'C the signs'¹²³

The **second** peer review meeting should take place towards the end of the QI activity and focus on:

- Celebrating success and sharing of key changes made in practice.
- Encouraging a compassionate, no-blame and active learning culture.
- How these changes have been embedded and will be sustained.

Discussion points could include:

- What results have each practice seen in their QI activity testing?
- What changes have been adopted in each practice?
- How will these changes be sustained in the future?
- What new skills have staff developed and how can they be used next?
- What further QI activity in cancer screening and early diagnosis is planned in each practice?
- What further actions may need to take place (e.g. at network or CCG level) to support the changes in practices?
- Not all changes are improvements, what has been tried and failed/ had unintended consequences?

v. Reporting and verification

The contractor will need to complete the QI monitoring template in relation to this module and self-declare that they have completed the activity described in their QI plan. The contractor will also self-declare that they have attended a minimum of two

¹²³ <https://cthesigns.co.uk/>

peer review meetings (either in person, when appropriate, or virtually) as described above, unless there are exceptional and unforeseen circumstances which impact on a contractor's ability to participate. In these circumstances' contractors are expected to make efforts to ensure alternative participation in peer review.

Verification - Commissioners may require contractors to provide a copy of the QI monitoring template as written evidence that the quality improvement activity has been undertaken. Commissioners may require the network clinical lead to provide written evidence of attendance at the peer review meetings. If a contractor has been unable to attend a meeting due to exceptional circumstances, then they will need to demonstrate other active engagement in network peer learning and review.

Alternative audits can be found in Appendix of the document <https://www.england.nhs.uk/wp-content/uploads/2020/02/20-21-qof-qi-cancer.pdf>

Care of people with learning disabilities

Indicator	Points	Achievement thresholds
QILD007. The contractor can demonstrate continuous quality improvement activity focused on care of patients with a learning disability as specified in the QOF guidance	27	NA
QILD008. The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity focused on the care of patients with a learning disability as specified in the QOF guidance. This would usually include participating in a minimum of two network peer review meetings	10	NA

Rationale

A learning disability is a significantly reduced ability to understand complex information or learn new skills; a reduced ability to cope independently; and a condition which started before adulthood with a lasting effect ([Valuing People, 2001](#)).

People with a learning disability experience significant health inequality:

- The gap between the age at death for people with a learning disabilities (age ≥4 years) and the general population (all ages) is 23 years for males and 27 years for females ([LeDeR, 2018](#)); the median age at death for someone with profound LD is 40 years.
- The commonest recorded causes of death in order are pneumonia, aspiration pneumonia, sepsis, dementia, CVD, epilepsy.

A confidential inquiry concluded that 42% of deaths for people with a learning disability are premature. The most common reasons are delays or problems with diagnosis or treatment, and problems with identifying needs and providing appropriate care in response to changing needs.

People with Learning Disabilities are significantly more likely to have co-morbidities. Since 2015, [Public Health England and NHS Digital](#) have examined GP records to monitor the prevalence of co-morbidities for half the population of England. The co-morbidities occurring more frequently in the learning disability population than the general population are obesity, asthma, constipation, dysphagia, GORD, epilepsy, dementia and mental health problems.

Currently only about 25% of the estimated 1.1 million people in England with a learning disability are recorded on the current Learning Disability QOF register ([Learning Disabilities Observatory, 2016](#)). Improving the accuracy of the QOF register will help ensure people with a learning disability are offered annual health checks.

The annual health check is an evidence-based tool recommend by NICE ([QS101](#), [QS187](#)). Health checks can identify undetected health conditions early, ensure the appropriateness of ongoing treatments and establish trust and support continuity of care. The [RCGP provides support](#) that practices can use. Health check action-planning provides the opportunity to positively promote health by encouraging cancer screening uptake, immunisations and healthy lifestyle. People with a learning disability are more likely to be obese, less likely to take up all national cancer screening offers and only 44.7% received a flu vaccination in 2018.

General practice has a key role in optimising prescribing to reduce harm (NICE [NG5](#), [QS120](#)). For people with a learning disability, this includes reviewing the over-prescribing of psychotropic medication in the absence of a mental health diagnosis (STOMP initiative [PHE, 2015](#)).

General practice can play a vital role in improving holistic person-centred care for people with a learning disability to enable them to live their ambition of fulfilled lives in the community. Providing holistic care can improve outcomes and ensure people live safely by raising awareness of the risk of abuse of vulnerable individuals. By treating people and their families with this dignity general practice will gain the respect of people with a learning disability.

Overview of the QI module

The overarching aim of this QI module is to improve care for people of all ages with a learning disability (with or without autism), including:

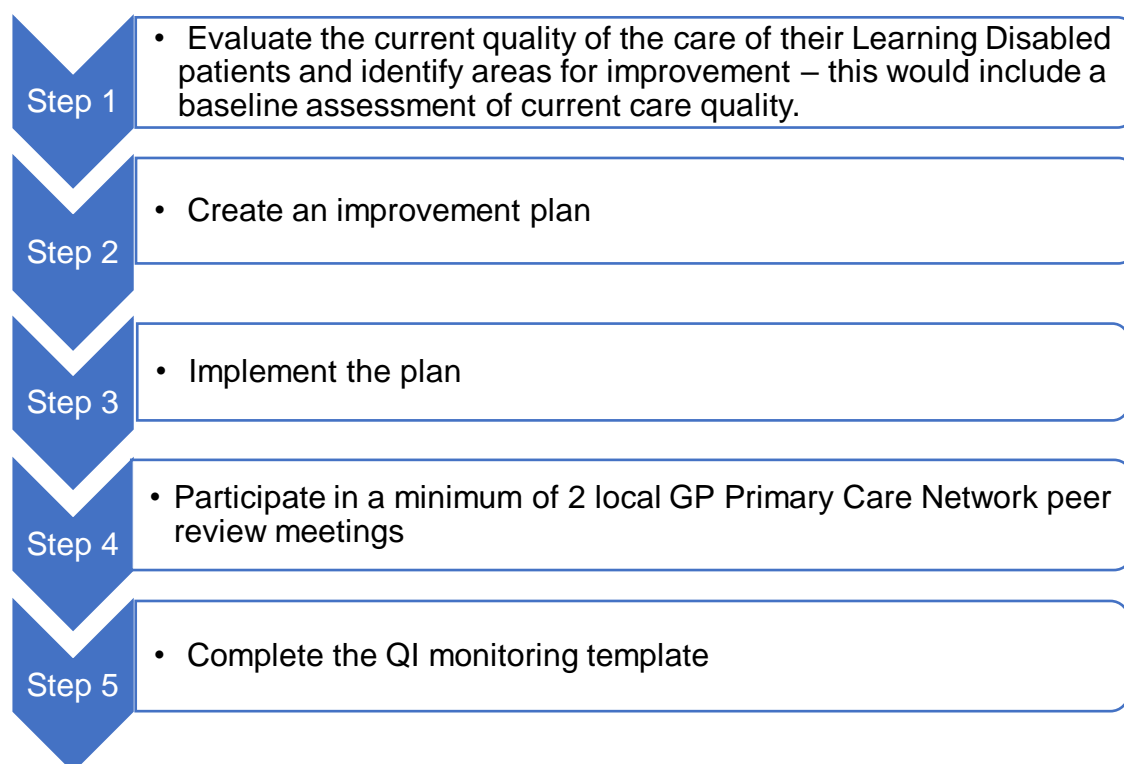
- 1) Improve the **accuracy of the GP register** by increasing the identification and coding of people of all ages with a learning disability including those with a dual diagnosis of learning disability and autism so that those on the register can be proactively invited for health checks, vaccinations etc. **Practices should ensure inclusion of any under-represented groups such as children and young people and people from BAME backgrounds.**
- 2) **Increased uptake of annual health checks** in people aged 14 and over, acting as an iterative process of personalised care planning to manage co-morbidities, reduce unnecessary hospitalisations, promote health positively and reduce premature mortality. The health check should always produce a personalised action plan to facilitate this. **A [health action plan](#) should be agreed with the patient and carer during the health check, and should be**

individually developed and based on an individual's physical and mental health and well-being. The health action plan should take account of any condition management issues identified as part of the annual health check. The health action plan should include any additional population-based screening, health improvement and health promotion considerations as required.

- 3) **Optimisation of medications** in line with the STOMP initiative (stopping over prescribing of medication for people with learning disability) with a focus on identifying those on antipsychotic medication to review the clinical appropriateness (in partnership with local MDT including psychiatry and social care) and to monitor side effects such as metabolic effects.
- 4) Recording of the need for, and type of, **reasonable adjustments** required and evidence that these are being implemented in practice as set out in the Equality Act and record preferred means of communication as required by the Accessible Information Standard.
- 5) **Implementing the learning from the 2019/20 LeDeR report**¹²⁴ to improve care for patients. This could include reviewing the co-ordination of care for people with a learning disability and reviewing processes on recognising acute deterioration in the health and mental wellbeing of a person with learning disabilities. The LeDeR report recommends a renewed focus on the safety of people with learning disabilities and epilepsy.
- 6) Consideration of the use of wider community support through **engagement with local community learning disability services and network social prescribers, in collaboration with people with a learning disability and their families and carers.**

¹²⁴ https://www.hqip.org.uk/wp-content/uploads/2020/07/LeDeR_2019_annual_report_FINAL.pdf

Practices will need to undertake the following steps:



The following section includes further detail on the types of things practices could do to deliver this module. These are suggestions only and the decision about what to include in the QI plan and which QI methodologies to use should be made by practices and shared with their peers through the network meetings.

Detailed contractor guidance

1. Identifying areas for improvement

All practices should start with an assessment of the current quality of care they provide to patients of all ages on the Learning Disability QOF register. This should include:

1. Improving the accuracy and increase prevalence of the Learning Disability QOF register by running searches of the NHS England provided codes to case-find people on the practice list who 'may' have a learning disability, using the [inclusion tool](#)¹²⁵ provided to determine whether the individual would benefit from being on the register and then adding the code 'on learning disability register' for those for whom this is appropriate. (Those currently on the practice list but not on the QOF register who 'will' have a learning disability will be automatically case-found and placed on the register from 1/1/2021)

¹²⁵ <https://www.england.nhs.uk/wp-content/uploads/2019/10/improving-identification-of-people-with-a-learning-disability-guidance-for-general-practice.pdf>

2. Completing a whole practice training needs analysis in learning disability awareness, awareness of the requirements of the Equality Act and awareness of implementation of the Mental Capacity Act.
3. Reflecting on the practice's overall approach to how it cares for people with learning disability including looking at practice data on the rate of annual health check completion, use of an approved health check electronic template, health promotion activity including, cancer screening and vaccination rates, long term condition management and healthy living indicators (e.g. obesity, smoking, drugs, alcohol, sexual health).
4. Evaluating by practice self-assessment, how reasonable adjustments are identified, highlighted and implemented including the accessible information standard.

For practices already completing high quality annual health checks, **on track to achieving** the national 75% uptake target, with application of well-received and 'consistent for the individual' reasonable adjustments, where quality of care provided by the health check is already monitored, then extended evaluation could include:

- Evaluation of the acute care of people with a learning disability by reviewing acute hospital admissions, repeat admissions, preventable admissions, failure to attend hospital appointments and investigations and by detailed mortality review if a death of a Learning Disabled person has occurred in the practice.
- Audit of adults on the QOF learning disability register but not on the QOF MH register who are currently prescribed an antidepressant, an antipsychotic or a benzodiazepine and those adults on the Learning Disability QOF register without a diagnosis of epilepsy who are currently taking an antidepressant.
- Audit of the numbers of adult patients on the Learning Disability QOF register who have a Summary Care Record with Additional Information.
- Audit of the numbers of patients on the Learning Disability QOF register who have a NHS Digital 'reasonable adjustment' flag (if available in the practice area) or alternative flag on their record.

Practices may also find it useful to undertake a reflective group meeting and/ or complete a SWOT analysis (strengths, weaknesses, opportunities, threats) of the practice's approach to identifying, managing the care of and supporting people with learning disabilities. Guidance on basic QI concepts and tools can be found in the NHS England [An Introduction to Quality Improvement in General Practice and the RCGP QI Ready tool](#). NHS England and the RCGP have also produced free support resources, in particular, the comprehensive Health Checks for People with Learning Disability Toolkit.¹²⁶

Practices may want to involve the local community learning disability services, where this is possible, to provide additional support and advice on identifying areas for improvement including case-finding, and to access local training opportunities. Local

¹²⁶ <https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/health-check-toolkit.aspx>

multi-disciplinary learning disability services can also support the provision of additional community-based support and personal health budgets.

2. Creating improvement plan

Following the diagnostic phase above, practices should focus their QI activities on the following outcomes:

1. Increase the number of people on the Learning Disability QOF register in order to enable these people to be proactively called for health checks and flu immunisations and have their needs for reasonable adjustments recorded and flagged.
2. Increase the uptake of high quality annual health checks, including health check action plans, to 75% of all those on the QOF Learning Disability Register aged 14 and over to enable excellent planned care to be provided to improve health outcomes.
3. Increase the numbers of people of all ages on the Learning Disability QOF register who have received an annual flu immunisation – the rationale being that respiratory infection is the commonest cause of death in people with a learning disability.
4. Improve the provision and understanding of Reasonable Adjustments by the practice including recording these using the Reasonable Adjustment Flag (if available in the practice area), using the Summary Care Record with Additional Information, ensuring adjustments needed are included in all communications from the practice and adhering to the Accessible Information Standard.

The outcomes listed will be used at a national level to assess the impact of the module and practices should consider how they measure improvement when choosing aims for their projects.

In parallel with this, the quality of the annual health check, robustness of care planning and impact on health care such as improvements in long term condition management and reduction of unnecessary hospital admission would be addressed. Quality improvement activity should focus on measurable impact.

Once practices have identified their area/s for improvement they should be clear about:

- **The aims** of the project – what will be achieved and by when. These aims should be SMART (specific, measurable, achievable, relevant, and time-bound).
- **The measures** – what data will be collected to know if the aims have been met. Measurements to assess the effectiveness of changes made should be straightforward for teams to collect regularly.
 - Process, e.g. numbers of people with a learning disability invited for health check / offered flu vaccination / with documented communication preference.
 - Outcomes, e.g. proportion of people with a learning disability having personalised health action plan in place / receiving flu vacc / showing improved management of a long-term condition, e.g. improved HbA1c or

- BP reading / taking up appropriate cancer screening / supported to stop smoking / reduce excessive alcohol intake)
- Balancing, e.g. checking the proportion of people with severe mental illness having a physical health check does not reduce (due to focus on learning disability)
- **The changes** – what different ways of doing things will be tested.

Practices should choose their own quality improvement activities and set their own targets for improvement based on their baseline audit or search results. These should be challenging but realistic and recognise that it may be easier to make larger improvements when starting from a modest baseline. These should be validated by network peers as part of the initial network review meeting. Multiple small tests of change are recommended.

Practices should aim to find a way to ensure improvement is continuous and that quality improvement becomes routine. See Box 3 for examples of SMART aims.

Practices should consider which QI tools and techniques are most suitable to support their improvement project. Examples include:

- Case finding exercise: a series of coding searches to find and re-code any missing cases (see resources section).
- [Process mapping](#) and reviewing how health check recalls and reminders are carried out and how the process is made as streamlined as possible (e.g. with blood tests carried out in time for results to be available to reduce unnecessary extra visits, methods of invitation of the individual to the appointment by their preferred method to reduce the rate of failure to attend, guidance to paid carers about importance of the check).
- Structured review with a focus group including patients, family members and their carers using a framework such as TEACH (time, environment, attitude, communication, and help) to map how the practice identifies, records and implements reasonable adjustments.
- Creating [run charts](#) to document the monthly measurement of achievement of aims such as numbers of completed health checks, medications reviews done, flu vaccinations completed, reasonable adjustment flags added, Summary Care Record with Additional Information added or screening invitations taken up.

Box 3. Examples of SMART aims practices could consider:

Area for improvement 1:

The practice learning disability register has not been checked for accuracy for many years. The practice follows the new guidance from NHS England on searches for codes showing patients on the list who 'may' have a learning disability.

SMART aim: To review the records and/or make contact with all identified individuals to determine whether they would benefit from being placed on the register. This will be done for x% of the list of those who 'may' have a learning disability each quarter with incremental progress through the year to y% by the end of 12 months.

Area for improvement 2:

The practice last year completed annual health checks on x% of people on its QOF learning disability register aged 14 and over.

SMART aim: To increase progressively the proportion of people on its QOF learning disability register aged 14 and over having a completed annual health check to (the national DES target of) 75% within y months.

Area for improvement 3:

The practice had no system for identifying and recording reasonable adjustments needed for people with learning disability.

SMART aim: To introduce a system that leads to x% of all patients with learning disability having an agreed digital flag (NHS Digital Reasonable Adjustment Flag or local alternative) within 12 months.

Area for improvement 4:

The practice had not recorded the preferred means of communication for invitation for the Health Check in the majority of patients and failed to invite for the health check by the preferred means.

SMART aim: To ensure that in incremental steps during the year x% of those aged 14 and over have preferred means of communication recorded in their notes and that this method is used to invite that x% to their health check in the coming year.

Area for improvement 5:

The practice identified that 45% of people on the learning disability QOF register had a recorded flu vaccination last year.

SMART aim: To increase the proportion of people on the learning disability QOF register receiving the flu vaccine - or declining through a valid, documented, informed consent process to x% within 12 months.

Area for improvement 6:

The practice found that 30% of female patients in the appropriate age group and on the learning disability register had attended for cervical cancer screening within recommended timescales. A staff survey identified the lack of confidence of practice nurses in assessing capacity and gaining consent and discussing sensitive sexual behaviour with women with a learning disability including the risk of sexual abuse.

SMART aim: All clinical staff offering cervical screening to undergo training in learning disability awareness, Mental Capacity Act and Adult Safeguarding in order

to support women with a learning disability to engage with cervical screening and sexual health promotion with all staff reporting increased confidence in this area within 6 months.

SMART aim: The practice will increase the proportion of women attending for cervical screening (or declining through a valid, documented informed consent process) to X% in the second 6 months of the year.

Area for improvement 7:

A patient registered with the practice and on the learning disability register died during the last 12 months. No documented review or significant / learning event analysis was held after the death.

SMART aim: Every death of a person on the LD register is considered as a significant event with a documented reflective analysis of what lessons the practice could learn including identification of good practice and areas for improvement.

3. Implementing the plan

Practices should implement the improvement plan they have developed to support the objectives they have identified. It is recommended that these plans and associated improvement activities should involve the whole practice team and practices are encouraged to engage with colleagues outside the practice, where practicable, for example local community learning disability services, social prescribers, network pharmacist, patient support groups, family carer groups and specialist third sector organisations.

Where possible, patients and their family members and carers should be involved in quality improvement activity around the health inequalities experienced by and the impact of the person's learning disability on their life. Local learning disability services may be able to assist using support of experts by experience, local advocacy services, and local learning disability carer groups.

Example case studies can be downloaded from <https://www.england.nhs.uk/wp-content/uploads/2020/02/20-21-qof-qi-cases-studies.pdf>

4. GP Network peer review meetings

A key objective of the network peer review meetings is to enable shared learning across the network. The aim of this is to improve learning from quality improvement activities referencing the need to improve outcomes from learning from the LeDeR (Learning Disability Mortality Review) process. It is important to recognise the vulnerability of people with a learning disability and their ability to access healthcare, factors which impact on the greater health inequalities they face. It is intended to provide a forum for practices to identify wider system issues impacting on care quality which may require a collective response.

Contractors should participate in a minimum of two network peer review discussions unless there are exceptional and unforeseen circumstances which impact on a contractor's ability to participate. Whilst these meetings would usually be face to face, networks are able to explore other mechanisms to facilitate real time peer learning and sharing including virtual meetings.

The peer review group will usually be the Primary Care Network of which the practice is a member. Where the practice is not part of a network their peer review group should be agreed with the commissioner. Suggested discussion points for these meetings are made in Box 4.

The network clinical lead or their nominated deputy should facilitate these meetings and maintain a record of attendance. It is for the network to determine the timing of these meetings, but it is recommended that the first meeting takes place early in the QI activity at the stage of deciding on what quality improvement activities to undertake and the second towards the end to share outcomes and learning from these activities.

Box 4. Suggested peer review meeting discussion points

The **first** peer review meeting should take place early in the QI activity and focus on:

- Sharing the outputs of baseline work to understand the issues for each practice concerning the quality of overall care provided to their Learning-Disabled patients
- Practices should be able to share data at the first peer review meeting. In order to monitor progress practices should share their previous year's health check uptake as a percentage of those aged 14 and over on the LD QOF register, their flu vaccination uptake as a percentage of all those of all ages on the LD QOF register and their LD prevalence data (numbers on register as a percentage of total practice population)
- Validation of practice improvement targets.

Discussion points could include:

- What relevant evidence-based guidance / quality standards can the group use?
- What data has each practice used to inform its review of current performance?
- Has the right focus been chosen by each practice based on their current performance?
- Has each practice set a clear aim with a challenging but realistic local target, and agreed an appropriate measurement to monitor impact?
- What ideas for changes is each practice planning to try in an improvement cycle?
- How are practices ensuring that the whole practice team (including other clinical colleagues and patients and carers) are engaged in the proposed QI activity?

The **second** peer review meeting should take place towards the end of the QI activity and focus on:

- Celebrating success and sharing of key changes made in practice.
- Encouraging a compassionate, no-blame and active learning culture.
- How these changes have been embedded and will be sustained.

Discussion points could include:

- What results have each practice seen in their QI activity testing?
- What changes have been adopted in each practice?
- How will these changes be sustained in the future?
- What new skills have staff developed and how can they be used next?

- What further QI activity is planned in each practice?
- What further actions may need to take place (e.g. at network or CCG level) to support the changes in practices?

5. Reporting and verification

The contractor will need to complete the QI monitoring template in relation to this module and self-declare that they have completed the activity described in their QI plan. The contractor will also self-declare that they have attended a minimum of two peer review meetings (either in person, where appropriate, or virtually) as described above, unless there are exceptional and unforeseen circumstances which impact on a contractor's ability to participate. In these circumstances' contractors are expected to make efforts to ensure alternative participation in peer review.

Verification - Commissioners may require contractors to provide a copy of the QI monitoring template as written evidence that the quality improvement activity has been undertaken. Commissioners may require the network clinical lead to provide written evidence of attendance at the peer review meetings. If a contractor has been unable to attend a meeting due to exceptional circumstances, then they will need to demonstrate other active engagement in network peer learning and review.

Resources are available to support available from <https://www.england.nhs.uk/wp-content/uploads/2020/02/20-21-qof-qi-supporting-people-with-learning-disabilites.pdf>

Section 6: Personalised care adjustment

As of 1 April 2019, exception reporting is being replaced with a Personalised Care Adjustment (PCA). This will allow practices to differentiate between the following reasons for adjusting care and removing a patient from the indicator denominator:

- *unsuitability* for the patient, e.g. because of medicine intolerance or allergy, or contra-indicated polypharmacy;
- *patient choice*, following a shared-decision making conversation;
- the patient *did not respond* to offers of care – recording of this will change to capture actual invitations sent to patients;
- the specific service is *not available* (in relation to a limited number of indicators only); or
- *newly diagnosed or newly registered* patients, as per existing rules.

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.

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

When considering whether a PCA applies to an individual patient practices are reminded that:

- the duty of care remains for all patients,
- 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
- 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 reviewed on a regular basis.

In each case where a personalised care adjustment is applied then 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

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.

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.

The hierarchy listed above seeks to prioritise 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

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

The investigative service or secondary care service is unavailable

This care adjustment will apply only to the following indicators: HF005, AST006, COPD008 and DM014.

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 CCG, if a suitable investigative or secondary service could be commissioned for the patient prior to entering a service unavailable code in the patient record.

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
HF005	Within 6 months of diagnosis of heart failure
AST006	Within 6 months of diagnosis of asthma
COPD008	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

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.

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.

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.

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.

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.

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

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, video conferencing or telephone contact between a health professional and the patient.

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.

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

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

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.¹²⁷ 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.

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.

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.

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.

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.

Invitations for cervical screening

As noted above, the requirement for women to be invited on three separate occasions will continue in line with national screening programme requirements. Therefore:

- In those areas where the first two invitations are sent via the central screening service, then contractors are responsible for offering the third invitation, or
- Where the central screening service sends out only one letter, then contractors are responsible for offering the second and third invitation.
- Where contractors have opted to run their own call/recall system then they are responsible for making all three invitations.

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.

¹²⁷ <https://www.england.nhs.uk/ourwork/accessibleinfo/>

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

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

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.

Section 7: Indicators no longer in QOF (INLIQ)

There are no changes to the INLIQ extraction from 1 April 2021. The indicators included in INLIQ in 2021/22 are detailed below.

Indicator ID	Indicator description
CHD003	The percentage of patients with coronary heart disease whose last measured cholesterol (measured in the preceding 12 months) is 5 mmol/l or less
CKD002	The percentage of patients on the CKD register in whom the last blood pressure reading (measured in the preceding 12 months) is 140/85 mmHg or less
CKD004	The percentage of patients on the CKD register whose notes have a record of a urine albumin:creatinine ratio (or protein:creatinine ratio) test in the preceding 12 months
NM84	The percentage of patients on the CKD register with hypertension and proteinuria who are currently treated with renin-angiotensin system antagonists
CVD-PP002	The percentage of patients diagnosed with hypertension (diagnosed after or on 1 April 2009) who are given lifestyle advice in the preceding 12 months for: smoking cessation, safe alcohol consumption and healthy diet
DM005	The percentage of patients with diabetes, on the register, who have a record of an albumin:creatinine ratio test in the preceding 12 months
DM011	The percentage of patients with diabetes, on the register, who have a record of retinal screening in the preceding 12 months
EP002	The percentage of patients 18 or over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the preceding 12 months
EP003	The percentage of women aged 18 or over and who have not attained the age of 55 who are taking antiepileptic drugs who have a record of information and counselling about contraception, conception and pregnancy in the preceding 12 months
LD002	The percentage of patients on the learning disability register with Down's syndrome aged 18 or over who have a record of blood TSH in the preceding 12 months
MH004	The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol:HDL ratio in the preceding 12 months
MH005	The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months
MH008	The percentage of women aged 25 or over and who have not attained the age of 65 with schizophrenia, bipolar affective disorder

	and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years.
PAD002	The percentage of patients with peripheral arterial disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less.
PAD003	The percentage of patients with peripheral arterial disease in whom the last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less
PAD004	The percentage of patients with peripheral arterial disease with a record in the preceding 12 months that aspirin or an alternative anti-platelet is being taken.
RA003	The percentage of patients with rheumatoid arthritis aged 30 or over and who have not attained the age of 85 who have had a cardiovascular risk assessment using a CVD risk assessment tool adjusted for RA in the preceding 12 months
RA004	The percentage of patients aged 50 or over and who have not attained the age of 91 with rheumatoid arthritis who have had an assessment of fracture risk using a risk assessment tool adjusted for RA in the preceding 24 months
SMOK001	The percentage of patients aged 15 or over whose notes record smoking status in the preceding 24 months
STIA005	The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA whose last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less
THY001	The contractor establishes and maintains a register of patients with hypothyroidism who are currently treated with levothyroxine
THY002	The percentage of patients with hypothyroidism, on the register, with thyroid function tests recorded in the preceding 12 months

Section 8: 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
CCG	Clinical Commissioning Group
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

Abbreviation	Definition
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
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
HbA1c	Glycated Haemoglobin
HBPM	Home Blood Pressure Monitoring

Abbreviation	Definition
HF	Heart Failure
HYP	Hypertension
IFCC	International Federation of Clinical Chemistry and Laboratory Medicine
INLIQ	Indicators no longer in in QOF
IQ	Intelligence Quotient
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
NHS CB	NHS Commissioning Board (NHS England)
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
OST	Osteoporosis
PAD	Peripheral Arterial Disease
PC	Palliative Care

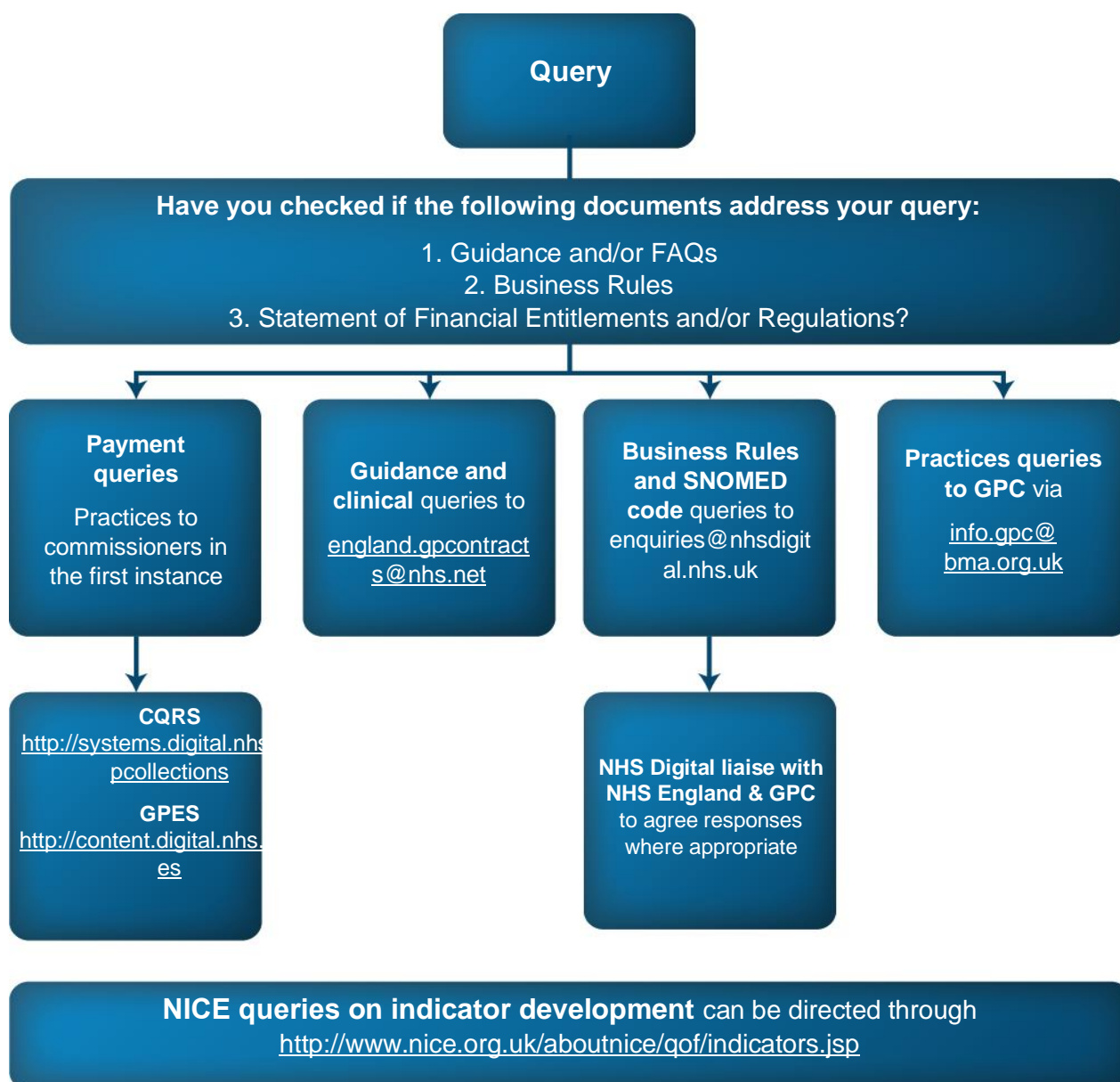
Abbreviation	Definition
PCA	Personalised Care Adjustment
PCRJ	Primary Care Respiratory Journal
PEF	Peak Expiratory Flow
PH	Public health
PPI	Proton pump inhibitor
PVD	Peripheral Vascular Disease
QI	Quality Improvement
QOF	Quality and Outcomes Framework
QS	Quality standard (NICE)
RA	Rheumatoid Arthritis
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
SWOT analysis	Strengths, weaknesses, opportunities and threats analysis
STIA	Stroke or Transient Ischemic Attack
TA	Technology appraisal (NICE)
TIA	Transient Ischemic Attack
TSH	Thyroid Stimulating Hormone
UK	United Kingdom
US	United States
WHO	World Health Organisation

Section 9: Queries

Queries fall into three main categories:

1. those which can be resolved by referring to guidance and/or FAQs
2. those requiring interpretation of the guidance or Business Rules¹²⁸
3. 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.



¹²⁸ NHS Digital. <http://content.digital.nhs.uk/qofextractspecs>

Section 10: Summary of clinical and public health indicator changes

New indicators

Nine new indicators are being introduced from 1 April 2021. The new vaccination and immunisation domain is listed in Table 3 below. The new serious mental health and cancer indicators are listed in Table 4 below.

Table 3: New vaccination and immunisation domain for 2021/22

Indicator ID	Indicator wording	Points	Payment thresholds	Points at lower threshold	Rationale for inclusion
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 (NICE 2020 menu ID: NM197)	18	90-95%	3	To support early vaccination with the hexavalent vaccine according to the routine immunisation schedule.
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 (NICE 2020 menu ID: NM198)	18	90-95%	7	To support early vaccination with the first dose of the MMR vaccine according to the routine immunisation schedule.
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	87-95%	7	To support immunisation according to the routine immunisation schedule. Measurement by 5 years old aims to

	(NICE 2020 menu ID: NM199)				achieve full immunisation against these infectious diseases before children start school.
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. (based on NM201)	10	50-60%	-	To support vaccination against shingles for patients 70 years old and over.

Table 4: New serious mental health and cancer indicators

Indicator ID	Indicator wording	Points	Payment thresholds	Rationale for inclusion
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 (based on NM15)	4	50-90%	To improve alcohol screening so as to ensure that people can access the support they may need to reduce their alcohol consumption.
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 who 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 (based on NM129)	8	50-90%	To monitor cholesterol so that healthcare practitioners can offer advice and treatment for raised cholesterol level, to reduce the risk of cardiovascular disease, when needed.

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 (NICE 2015 menu ID: NM130)	8	50-90%	To monitor blood glucose or HbA1c so that healthcare practitioners can offer preventative advice and treatment for diabetes if needed.
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 (NICE menu 2020 ID: NM205)	6	50-90%	To encourage GP practices to conduct a cancer care review which represents an initial opportunity to address patients' needs for individual assessment, care planning and ongoing support and information requirements using a structured template at a time that is appropriate for the individual patient.
CAN005	The percentage of patients with cancer, diagnosed within the preceding 12 months, who have had the opportunity for a discussion and been informed of the support available from primary care, within 3 months of diagnosis (based on NM204)	2	70-90%	To ensure patients are aware of the support available from their GP and wider practice team soon after their diagnosis and how this can complement the care they are receiving in secondary care.

Retired indicators

Four indicators have been retired from April 2021. These are listed in Table 5 below.

Table 5: Indicators retired from April 2021

Indicator ID	Indicator wording	Points	Rationale for retirement
COPD007	The percentage of patients with COPD who have had influenza immunisation in the preceding 1 August to 31 March	6	Incentives to support seasonal influenza vaccination coverage will be in the IIF from 2021/22.
DM018	The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 August to 31 March	3	
STIA009	The percentage of patients with stroke or TIA who have had influenza immunisation in the preceding 1 August to 31 March	2	
CHD007	The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 August to 31 March	7	
CAN003	The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient Cancer Care Review using a structured template recorded as occurring within 6 months of the date of diagnosis.	6	Timing of the cancer care review amended

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