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NHS England

Quality and Outcomes Framework guidance for 2025/26

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Contents

1. Introduction

1.1 Purpose of this document

i. This document provides additional guidance on the interpretation and verification of the QOF indicators for 2025/26 in England, which are listed in Annex D of the Statement of Financial Entitlements Directions (SFE)[1]. It is effective from 1 April 2025 and replaces versions issued in previous years.

ii. This document covers:

- Section 2: the list of QOF indicators as detailed in Annex D of the SFE Directions
- Section 3: specific information about each clinical indicator including the rationale for inclusion and any specific requirements which contractors need to demonstrate to ensure achievement
- Section 4: specific information about each public health indicator including the rationale for inclusion and any specific requirements which contractors need to demonstrate to ensure achievement
- Section 5: detailed information about personalised care adjustments
- Section 6: glossary of acronyms
- Section 7: the process for raising queries in relation to QOF indicators and their interpretation

iii. This guidance should be read in conjunction with the SFE Directions and business rules.

1.2 Definition of 'commissioner'

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

1.3 Additional indicator information

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

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

Clinical and public health indicators

i. Clinical and public health indicators are organised by disease or intervention categories. These indicators have been selected as they represent care where:

- the responsibility for ongoing management rests principally with the contractor and the primary care team
- there is good evidence of the health benefits likely to result from improved primary care

Indicator numbering

i. Indicators are prefixed with an abbreviation of the category to which they belong. Indicator IDs are unique to each indicator and are not reused. For example, the indicators for coronary heart disease are identified as CHD005, CHD015 and CHD016. New indicators will be given the next available unused number. Therefore, this may not flow sequentially from the existing indicator IDs. Similarly, where there has been a change to indicator wording, activity timescales or significant changes to coding or the data extraction logic these indicators will be given a new unique ID. This is to ensure that indicators are not inappropriately compared to those in previous years and to avoid any confusion which could arise from re-using ID numbers.

ii. Where an indicator has been developed through the NICE led process[2] they will also be annotated with their NICE menu ID number NICE INDXX). If a NICE developed indicator has been amended during negotiations this will be annotated with 'based on NICE INDXX'. 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

i. Clinical indicators all have a defined target population. This is defined 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

[2] https://www.nice.org.uk/standards-and-indicators/indicators

denominator for each indicator. Where the target population is identified using clinical codes the contractor is responsible for demonstrating that it has systems in place to maintain a high quality, accurate register. This may be verified by the commissioner and contractors may be asked to explain reasons for variation from expected prevalence levels. Contractors are reminded that QOF registers must not be used as the sole input for the purposes of patient care and clinical audit. There may be patients for whom a treatment or activity is clinically appropriate, but they may not meet the criteria as defined by the QOF register. Contractors are asked to hold this in mind when developing call/recall systems.

ii. Patients with co-morbidities will be included in all relevant target populations and registers where they meet the defined criteria. Where a patient is in more than one target population, they are eligible for the interventions outlined in all relevant disease areas.

iii. Some indicators refer to a sub-set of patients in the target population or register. Patients who are not included in an indicator denominator for definitional reasons are classified as ‘exclusions’ and are automatically identified through the business rules and removed from the denominator.

iv. Patients are eligible for the interventions outlined in QOF indicators as soon as they are fully registered with the contractor, or a relevant diagnosis is recorded.

v. Where a practice does not have registered patients within a particular cohort, no specific care interventions are needed and so QOF points will not be earnable.

1.4 Reporting, payment calculation and verification

Reporting

i. Reporting requirements and the rules for the calculation of QOF points and their payment are set out in the SFE. For most indicators, anonymised data will be collected automatically from GP clinical systems by the General Practice Extraction Service (GPES) and reported to the Calculating Quality Reporting Service (CQRS).

ii. The clinical codes and logical extraction sequence used in this data collection is defined in a series of technical documents – the business rules. These are based entirely on SNOMED codes and associated dates, combined with patient characteristics (e.g. age and sex). SNOMED codes are an NHS standard. Contractors using proprietary coding systems and/or local/practice specific codes will need to be

aware that these codes will not be recognised within QOF reporting. The business rules are available on the NHS Digital website.

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

Payment calculation and achievement

i. CQRS will calculate achievement and payments for QOF as set out in the SFE and report to commissioners and practices. Whilst full details of the achievement calculations are detailed in the SFE, the following key points are useful to note:

- Achievement is measured on the last day of the financial year (i.e. 31 March) in respect of patients registered with the practice on that date. Whilst estimates of achievement may be made through the year, these may not accurately predict final performance.
- The time period referred to in an indicator is calculated by counting back from the last day of the financial year. Time periods vary between indicators.
- The phrase ‘currently treated’ should be interpreted as a prescription for the specified medication being given in the six months preceding the last day of the financial year (i.e. between 1 October and 31 March).
- Some indicators require the intervention to be offered to patients when they reach a defined age or within a specified time before and/or after diagnosis. Care recorded outside of these time periods will not be recognised in the QOF achievement calculation.

ii. There are specific provisions within the SFE which describe the calculations to be made where a contract comes to an end before the last day of the financial year.

Verification

i. The contractor must ensure that it is able to provide any information that the 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.

ii. Commissioners and practices will be aware of the requirements of access to patient identifiable data, in particular that they should:

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

iii. Where patients have expressed a desire that their information is not shared for this purpose, practices will need to advise the commissioner and make an appropriate note in the record. It is recommended that practices record access to confidential patient data in the relevant patient record, so that an audit trail is in place to fulfil the obligations of the practice towards their patients and that of commissioners to practices.

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

1.5 Disputes

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

2. Summary of all indicators

2.1 Clinical domain (437 points)

This domain applies to all contractors participating in QOF.

Atrial fibrillation (AF)	Points	Thresholds
Ongoing management		
AF006. The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA_2DS_2-VASc score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous $CHADS_2$ or CHA_2DS_2-VAS_c score of 2 or more)	12	40-90%

AF008. Percentage of patients on the QOF Atrial Fibrillation register and with a CHA2DS2- VASc score of 2 or more, who were prescribed a direct-acting oral anticoagulant (DOAC), or, where a DOAC was declined or clinically unsuitable, a Vitamin K antagonist	12	70-95%
Secondary prevention of coronary heart disease (CHD)	**Points**	**Thresholds**
Ongoing management		
CHD005. The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken	7	56–96%
CHD015. The percentage of patients aged 79 years or under, with coronary heart disease, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less, (or equivalent home blood pressure reading)	33	40-90%
CHD016. The percentage of patients aged 80 years or over, with coronary heart disease, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less, (or equivalent home blood pressure reading)	14	46-90%
Cholesterol control and lipid management (CHOL)	**Points**	**Thresholds**
Ongoing management		
CHOL003. Percentage of patients on the QOF Coronary Heart Disease, Peripheral Arterial Disease, Stroke/TIA or Chronic Kidney Disease Register who are currently prescribed a statin, or where a statin is declined or clinically unsuitable, another lipid-lowering therapy	38	70-95%
CHOL004. Percentage of patients on the QOF Coronary Heart Disease (CHD), Peripheral Arterial Disease (PAD), or Stroke/	44	20-50%

Transient Ischaemic Attack (TIA) Register, with the most recent cholesterol measurement in the preceding 12 months, showing as ≤ 2.0 mmol/L if it was an LDL (Low-density Lipoprotein) cholesterol reading or ≤ 2.6 mmol/L if it was a non-HDL (High-density Lipoprotein) cholesterol reading. For multiple readings on the latest date the LDL reading takes priority		
Heart failure (HF)	**Points**	**Thresholds**
Initial diagnosis		
HF008. The percentage of patients with a diagnosis of heart failure on or after 1 April 2023 which: 1. Has been confirmed by an echocardiogram or by specialist assessment in the 6 months before entering on to the register; or 2. If registered at the practice after diagnosis, with no record of the diagnosis originally being confirmed either by echocardiogram or by specialist assessment, a record of an echocardiogram or a specialist assessment within 6 months of the date of registration.	6	50–90%
Ongoing management		
HF003. In those patients with a diagnosis of heart failure due to left ventricular systolic dysfunction or whose heart failure is due to reduced ejection fraction the percentage of patients who are currently treated with an angiotensin-converting enzyme inhibitor (ACE-I) or Angiotensin II receptor blockers (ARB)	6	60–92%
HF006. The percentage of patients with a diagnosis of heart failure due to left ventricular systolic dysfunction or whose	6	60-92%

heart failure is due to reduced ejection fraction, who are currently treated with a beta-blocker licensed for heart failure		
HF007. The percentage of patients with a diagnosis of heart failure on the register, who have had a review in the preceding 12 months, including an assessment of functional capacity and a review of medication to ensure medicines optimisation at maximal tolerated doses	7	50-90%
Hypertension (HYP)	**Points**	**Thresholds**
Ongoing management		
HYP008. The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (or equivalent home blood pressure reading)	38	40-85%
HYP009. The percentage of patients aged 80 years or over, with hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less, (or equivalent home blood pressure reading)	14	40-85%
Stroke and transient ischaemic attack (STIA)	**Points**	**Thresholds**
Ongoing management		
STIA007. The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 12 months that an anti-platelet agent, or an anti-coagulant is being taken	4	57–97%
STIA014. The percentage of patients aged 79 years or under, with a history of stroke or TIA, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (or equivalent home blood pressure reading)	8	40-90%

STIA015. The percentage of patients aged 80 years or over, with a history of stroke or TIA, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less, (or equivalent home blood pressure reading)	6	46-90%
Diabetes mellitus (DM)	**Points**	**Thresholds**
Ongoing management		
DM006. The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs)	3	57–97%
DM012. The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 12 months	4	50–90%
DM014. The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register	11	40–90%
DM036. The percentage of patients with diabetes, on the register aged 79 years and under, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (or equivalent home blood pressure reading)	27	38-90%

DM020. The percentage of patients with diabetes, on the registers, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months	17	35-75%
DM021. The percentage of patients with diabetes, on the register, with moderate or severe frailty in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months	10	52-92%
DM034. 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) or where a statin is declined or if clinically unsuitable, another lipid-lowering therapy	4	50-90%
DM035. The percentage of patients with diabetes and a history of cardiovascular disease (excluding haemorrhagic stroke) who are currently treated with a statin or where a statin is declined or if clinically unsuitable, another lipid-lowering therapy	2	50-90%
Asthma (AST)	**Points**	**Thresholds**
Initial diagnosis		
AST012. The percentage of patients with a new diagnosis of asthma on or after 1 April 2025 with a record of an objective test between 3 months before or 3 months after diagnosis	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, a	20	45–70%

recording of the number of exacerbations, an assessment of inhaler technique and a written personalised action plan		
Chronic obstructive pulmonary disease (COPD)	**Points**	**Thresholds**
Ongoing management		
COPD010. The percentage of patients with COPD on the register, who have had a review in the preceding 12 months, including a record of the number of exacerbations and an assessment of breathlessness using the Medical Research Council dyspnoea scale	9	50–90%
Dementia (DEM)	**Points**	**Thresholds**
Ongoing management		
DEM004. The percentage of patients diagnosed with dementia whose care plan has been reviewed in the preceding 12 months	14	35–70%
Mental health (MH)	**Points**	**Thresholds**
Ongoing management		
MH002. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate	5	40–90%
MH003. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months	3	50–90%

MH006. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months	3	50-90%
MH007. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months	3	50-90%
MH011. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of a lipid profile in the preceding 12 months (in those patients currently prescribed antipsychotics, and/or have pre-existing cardiovascular conditions, and/or smoke, and/or are overweight (BMI of >=23 kg/m2 or >=25 kg/m2 if ethnicity is recorded as White)) or preceding 24 months for all other patients	7	50-90%
MH012. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months	7	50-90%
Non-diabetic hyperglycaemia (NDH)	**Points**	**Thresholds**
Records		
NDH002. The percentage of patients with non-diabetic hyperglycaemia who have had an HbA1c or fasting blood glucose performed in the preceding 12 months	18	50–90%

2.2 Public health domain (127 points)

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

Blood pressure (BP)	Points	Thresholds
BP002. The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years	15	50–90%
Smoking (SMOK)	**Points**	**Thresholds**
Records		
SMOK002. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months	25	50–90%
Ongoing management		
SMOK004. The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 24 months	12	40–90%
Vaccination and Immunisations (VI)	**Points**	**Thresholds**
VI001. The percentage of babies who reached 8 months old in the preceding 12 months, who have received at least 3 doses of a diphtheria, tetanus and pertussis containing vaccine before the age of 8 months	18	89-96%
VI002. The percentage of children who reached 18 months old in the preceding 12 months, who have received at least 1 dose of MMR between the ages of 12 and 18 months	18	86-96%
VI003. The percentage of children who reached 5 years old in the preceding 12 months, who have received a reinforcing dose of DTaP/IPV and at least 2 doses of MMR between the ages of 1 and 5 years	18	81-96%

VI004. The percentage of patients who reached 80 years old in the preceding 12 months, who have received a shingles vaccine between the ages of 70 and 79 years	10	50-60%

2.3 Public health domain – additional services sub-domain

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

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

3. Clinical domain

3.1 Atrial fibrillation (AF)

Indicator	Points	Thresholds
Ongoing management		
AF006. The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA_2DS_2-VASc score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous CHADS2 or CHA_2DS_2-VAS_c score of 2 or more)	12	40-90%

AF008. Percentage of patients on the QOF Atrial Fibrillation register and with a CHA2DS2- VASc score of 2 or more, who were prescribed a direct-acting oral anticoagulant (DOAC), or, where a DOAC was declined or clinically unsuitable, a Vitamin K antagonist	12	70-95%

AF – rationale for inclusion of indicator set

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

AF006 (based on NICE IND127)

AF006 Rationale

i. The NICE guideline on atrial fibrillation[3] recommends that people with symptomatic or asymptomatic paroxysmal, persistent or permanent AF, atrial flutter or a continuing risk of arrhythmia recurrence after cardioversion back to sinus rhythm should have an assessment of their stroke risk using the CHA_2DS_2-VAS_c risk assessment tool.

ii. The CHA2DS2-VASc system scores one point, up to a maximum of nine, for each of the following risk factors (except previous stroke or TIA, or age ≥75 which scores double, hence the '2'):

- C: congestive HF (one point)
- H: hypertension (one point)
- A_2: age 75 or over (two points)
- D: diabetes mellitus (one point)
- S_2: 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)

[3] NICE NG196 Atrial fibrillation (2021) http://www.nice.org.uk/Guidance/NG196

- Sc: sex category (i.e. female sex) (one point)

AF006 Reporting and verification

i. See indicator wording for requirement criteria.

ii. Stroke risk assessment should be repeated on an annual basis unless the patient has previously scored 2 or more using either CHA_2DS_2-VAS_c at any time, or $CHADS_2$ prior to 1 April 2015.

AF008 (based on NICE IND247)

AF008 Rationale

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

ii. The risk of stroke is five times higher for patients with AF than for the general population, and 20–30% of all strokes are attributed to this arrhythmia. The Stroke Association estimate that if AF were adequately treated, around 7,000 strokes would be prevented and over 2,000 lives saved every year in England alone.

iii. The NHS Long Term Plan commits to reducing stroke in England in three ways:

- diagnosing more patients with undiagnosed AF (the “detect” gap)
- ensuring patients diagnosed with AF are offered anticoagulation where appropriate (the “protect” gap)
- optimising the anticoagulant pathway to ensure patient outcomes are optimised (the “perfect” gap)

iv. This indicator has been developed to support LTP ambitions on the “protect” gap and complement QOF indicator AF007, which rewards practices for ensuring that up to 95% of patients on their AF register who are at risk of stroke are anticoagulated. It has two objectives:

- To increase the overall percentage of AF patients at risk of stroke who are prescribed an anticoagulant
- To increase the use of DOACs as a proportion of anticoagulants prescribed

v. Anticoagulation therapy can prevent around two thirds of strokes caused by AF. However, approximately 9% of patients with AF who are at risk of stroke are not on any form of anticoagulant.

vi. NICE guidance was updated in 2021 (NG196) to recommend that clinicians prescribe DOACs, rather than Warfarin as first-line treatment for patients with AF. Warfarin is associated with a more significant risk of serious bleeding (particularly intracranial haemorrhage) than DOACs. DOACs also do not require as much monitoring, freeing up capacity in primary care and improving quality of life for patients. Other benefits of DOACs over Warfarin include:

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

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

AF008 Reporting and verification

i. See indicator wording for requirement criteria.

3.2 Secondary prevention of coronary heart disease (CHD)

Indicator	Points	Thresholds
Ongoing management		

CHD005. The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken	7	56–96%
CHD015. The percentage of patients aged 79 years or under, with coronary heart disease, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less, (or equivalent home blood pressure reading)	33	40-90%
CHD016. The percentage of patients aged 80 years or over, with coronary heart disease, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less, (or equivalent home blood pressure reading)	14	46-90%

CHD – rationale for inclusion of indicator set

i. CHD is the single most common cause of premature death in the UK[4]. The research evidence relating to the management of CHD is well established and if these indicators are properly implemented can reduce the risk of death from CHD and improve the quality of life for patients. This indicator set focuses on the management of patients with established CHD.

CHD005 (based on NICE IND132)

CHD005 Rationale

i. NICE guidance[5] recommends all people who have had an MI should be offered aspirin (or clopidogrel if aspirin is contraindicated). Antiplatelet therapy with clopidogrel is equivalent to aspirin in preventing further cardiovascular events in people with coronary heart disease or ischaemic stroke.

CHD005 Reporting and verification

i. See indicator wording for requirement criteria.

[4] bhf-cvd-statistics-uk-factsheet.pdf (ims.gov.uk)
[5] NICE NG185 Acute coronary syndromes (2020) http://guidance.nice.org.uk/NG185

CHD015 (based on NICE IND241)

CHD015 Rationale

i. This indicator measures the intermediate outcome of a blood pressure of 140/90 mmHg or less in people aged 79 years or under with CHD. The aim is to promote secondary prevention of cardiovascular disease through satisfactory blood pressure control. This may be achieved through lifestyle advice or drug therapy.

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

CHD015 Reporting and verification

i. See indicator wording for requirement criteria.

CHD016 (based on NICE IND242)

CHD016 Rationale

i. This indicator measures the intermediate outcome of a blood pressure of 150/90 mmHg or less in people aged 80 years and over with coronary heart disease, as recommended by the NICE clinical guideline for hypertension[6].

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

CHD0016 Reporting and verification

i. See indicator wording for requirement criteria.

[6] NICE NG136 (2019, updated 2023) Hypertension in adults http://www.nice.org.uk/guidance/ng136

3.3 Cholesterol control and lipid management (CHOL)

Indicator	Points	Thresholds
Ongoing management		
CHOL003. Percentage of patients on the QOF Coronary Heart Disease, Peripheral Arterial Disease, Stroke/TIA or Chronic Kidney Disease Register who are currently prescribed a statin, or where a statin is declined or clinically unsuitable, another lipid-lowering therapy	38	70-95%
CHOL004. Percentage of patients on the QOF Coronary Heart Disease (CHD), Peripheral Arterial Disease (PAD), or Stroke/ Transient Ischaemic Attack (TIA) Register, with the most recent cholesterol measurement in the preceding 12 months, showing as ≤ 2.0 mmol/L if it was an LDL (Low-density Lipoprotein) cholesterol reading or ≤ 2.6 mmol/L if it was a non-HDL (High-density Lipoprotein) cholesterol reading. For multiple readings on the latest date the LDL reading takes priority	44	20-50%

CHOL – rationale for inclusion of indicator set

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

CHOL003 (Based on NICE IND230)

CHOL003 Rationale

i. The aim of this indicator is to ensure that all patients with established cardiovascular disease, defined as Coronary Heart Disease, Peripheral Arterial Disease, Stroke/TIA or Chronic Kidney Disease receive treatment to reduce cholesterol in line with NICE guidelines, summarised here: https://www.england.nhs.uk/aac/publication/summary-of-national-guidance-for-lipid-management/

ii. Treatment with a high intensity statin is recommended as first line therapy for the secondary prevention of CVD[7]. Options recommended by NICE when a high intensity statin is declined or clinically unsuitable due to contraindications or intolerance include:

- Ezetimibe[8], with the addition of bempedoic acid[9] if a sufficient fall in cholesterol is not achieved with ezetimibe monotherapy.
- PCSK9 inhibitors[10][11] for people with an LDL persistently above 3.5 or 4.0 mmol/L depending on their CVD risk profile.
- Inclisiran[12] for people with an LDL persistently 2.6mmol/L or above.

iii. Where a high intensity statin is declined or clinically unsuitable due to contraindications or intolerance, these treatments will be included as a 'success'.

CHOL003 Reporting and verification

i. See indicator wording for requirement criteria.

CHOL004 (based on NICE IND278)

CHOL004 Rationale

i. The purpose of the indicator is to introduce an interim outcome measure for the use of lipid lowering treatments outlined in CHOL003, for patients with established cardiovascular disease. This aims to ensure that all patients with established cardiovascular disease, defined as Coronary Heart Disease, Peripheral Arterial Disease, or Stroke/TIA are considered for intensification of therapy where there is an insufficient reduction in cholesterol with first line therapy, usually a high intensity statin.

[7] NICE NG238 (2023) Cardiovascular disease: risk assessment and reduction, including lipid modification. https://www.nice.org.uk/guidance/ng238
[8] NICE TA 385 (2022) Ezetimibe for treating primary heterozygous-familial and non-familial hypercholesterolaemia. https://www.nice.org.uk/guidance/ta385
[9] NICE TA694 (2021) Bempedoic acid with ezetimibe for treating primary hypercholesterolaemia or mixed dyslipidaemia. https://www.nice.org.uk/guidance/ta694
[10] NICE TA393 (2016) Alirocumab for treating primary hypercholesterolaemia and mixed dyslipidaemia. https://www.nice.org.uk/guidance/ta393
[11] NICE TA394 (2016) Evolocumab for treating primary hypercholesterolaemia and mixed dyslipidaemia. https://www.nice.org.uk/guidance/ta394
[12] NICE TA733 (2021) Inclisiran for treating primary hypercholesterolaemia or mixed dyslipidaemia. https://www.nice.org.uk/guidance/ta733

ii. The aim of managing LDL cholesterol to 2.0 mmol/L or lower or non-HDL cholesterol to 2.6 mmol/L or lower is aligned with the NICE guideline NG238 for Cardiovascular disease: risk assessment and reduction, including lipid modification. The full guideline can be found here: https://www.nice.org.uk/guidance/ng238.

iii. Where there is an insufficient reduction in cholesterol, treatment should be intensified in line with NICE guidance which is summarised here: https://www.england.nhs.uk/aac/publication/summary-of-national-guidance-for-lipid-management/.

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

CHOL004 Reporting and verification

i. See indicator wording for requirement criteria.

3.4 Heart failure (HF)

Indicator	Points	Thresholds
Initial diagnosis		
HF008. The percentage of patients with a diagnosis of heart failure on or after 1 April 2023 which: 1. Has been confirmed by an echocardiogram or by specialist assessment in the 6 months before entering on to the register; or 2. If registered at the practice after diagnosis, with no record of the diagnosis originally being confirmed either by echocardiogram or by specialist assessment, a record	6	50–90%

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

HF – rationale for inclusion of indicator set

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

HF008 (based on NICE IND192)

HF008 Rationale

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

ii. Symptoms and signs suggestive of heart failure are not sufficient to make a definitive diagnosis and further investigation is required to confirm cardiac dysfunction and to identify causes. The NICE guideline for chronic heart failure[13] recommends that the results of NT-proBNP tests should be used to determine whether people with suspected heart failure should be referred onwards. People with raised NT-proBNP should have echocardiography and specialist assessment within 6 weeks, but for those with very high levels this should be done more urgently, within 2 weeks. The NICE guideline for acute heart failure[14] recommends that people with new suspected acute heart failure who have raised natriuretic peptides should have echocardiography within 48 hours of admission to hospital.

HF008 Reporting and verification

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

HF003 (based on NICE IND193)

HF003 Rationale

i. There is strong clinical and cost-effectiveness evidence to support the use of ACE-I in all patients with HF with LVSD. ACE-I improve symptoms, reduce the hospitalisation rate and improve the survival rate. This is applicable in all age groups.

ii. It is possible to have a diagnosis of LVSD without HF, for example, asymptomatic people who might be identified coincidently but who are at high risk of developing subsequent HF. In such cases, ACE-I's delay the onset of symptomatic HF, reduce cardiovascular events and improve long-term survival. This indicator only applies to patients with HF and therefore excludes this other group of patients who are nevertheless to be considered for treatment with ACE-I.

iii. NICE NG106 recommends ACE-I is used as first-line therapy in all patients with HF with reduced ejection fraction usually defined as LVSD and that ARBs are used only in patients who are intolerant of ACE-I.

iv. Therapies should be titrated upwards until the target or maximum tolerated dose is reached.

[13] NICE NG106 (2018) Chronic heart failure in adults. https://www.nice.org.uk/guidance/ng106
[14] NICE CG187 (2014, updated 2021) Acute heart failure. https://www.nice.org.uk/guidance/cg187

HF003 Reporting and verification

i. See indicator wording for requirement criteria.

HF006 (based on NICE IND194)

HF006 Rationale

i. The NICE guideline for chronic heart failure[15] recommends that beta-blockers licensed for HF are used as first-line therapy in all patients with HF with reduced ejection fraction usually defined as LVSD. It also recommends that treatment with beta-blockers is not withheld solely because of age or the presence of peripheral vascular disease (PVD), erectile dysfunction (ED), DM, interstitial pulmonary disease and COPD without reversibility. The only co-morbidities with a clear contra-indication to beta-blocker use are those with asthma and reversible airways obstruction (these groups were excluded from clinical trials).

ii. The British National Formulary (BNF) states that "the beta-blockers bisoprolol and carvedilol are of value in any grade of stable HF and LVSD; nebivolol is licensed for stable mild to moderate HF in patients aged over 70, beta-blocker treatment should be initiated at a very low dose and titrated very slowly over a period of weeks or months by those experienced in the management of HF. Symptoms may deteriorate initially, calling for adjustment of concomitant therapy"[16].

iii. Contractors are advised that patients already prescribed an unlicensed beta-blocker prior to diagnosis of HF due to LVSD do not have their drug therapy changed to meet the criteria of this indicator. Those patients already prescribed an unlicensed beta-blocker will be excluded from the indicator denominator.

iv. Therapies should be titrated upwards until the target or maximum tolerated dose is reached.

HF006 Reporting and verification

i. See indicator wording for requirement criteria.

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

[15] NICE NG106 (2018) Chronic heart failure. https://www.nice.org.uk/guidance/ng106
[16] BNF. http://www.evidence.nhs.uk/formulary/bnf/current

HF007 (based on NICE IND195)

HF007 Rationale

i. Regular review is associated with improvement in quality of life and a reduction in the need for urgent hospitalisation. NICE guideline NG106 recommends short monitoring intervals (days to 2 weeks) if the clinical condition or medication has changed and 6-monthly for people with stable heart failure.

ii. More detailed monitoring will be needed if the person has significant comorbidity or if their condition has deteriorated since the previous review, with consideration for individualised care for frailty and palliative and end of life care.

HF007 Reporting and verification

i. See indicator wording for requirement criteria.

3.5 Hypertension (HYP)

Indicator	Points	Thresholds
Ongoing management		
HYP008. The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (or equivalent home blood pressure reading)	38	40-85%
HYP009. The percentage of patients aged 80 years or over with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less (or equivalent home blood pressure reading)	14	40-85%

HYP008 (based on NICE IND239)

HYP008 Rationale

i. This indicator measures the intermediate outcome of a blood pressure of 140/90 mmHg or less in people aged 79 years or under with hypertension. Its intent is to promote the primary and secondary prevention of cardiovascular disease through

satisfactory blood pressure control. The intermediate outcome can be achieved through lifestyle advice or the use of drug therapy.

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

HYP008 Reporting and verification

i. See indicator wording for requirement criteria.

HYP009 (based on NICE IND240)

HYP009 Rationale

i. The NICE guideline for hypertension[17] recommends that patients aged 80 years and over with hypertension should be treated to a target blood pressure below 150/90 mmHg. It also recommends that this group of patients should be offered the same antihypertensive drug treatment as people aged 55-80 years, taking into account any co-morbidities.

ii. Where people have had a lower treatment target before the age of 80 years their treatment should continue and not be adjusted or down titrated. There is an important distinction between continuing long term and well tolerated treatment in people aged 80 years and older and starting blood pressure lowering therapy at this age.

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

HYP009 Reporting and verification

i. See indicator wording for requirement criteria.

[17] NICE NG136 (2019, updated 2023) Hypertension in adults. http://www.nice.org.uk/guidance/ng136

3.6 Stroke and TIA (STIA)

Indicator	Points	Thresholds
Ongoing management		
STIA007. The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 12 months that an anti-platelet agent, or an anti-coagulant is being taken	4	57–97%
STIA014. The percentage of patients aged 79 years or under, with a history of stroke or TIA, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (or equivalent home blood pressure reading)	8	40-90%
STIA015. The percentage of patients aged 80 years or over, with a history of stroke or TIA, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less, (or equivalent home blood pressure reading)	6	46-90%

STIA – rationale for inclusion of indicator set

i. Stroke is the third most common cause of death in the developed world. One quarter of stroke deaths occur under the age of 65. There is evidence that appropriate diagnosis and management can improve outcomes[18].

STIA007 (based on NICE IND133)

STIA007 Rationale

i. Long-term anti-platelet therapy reduces the risk of serious vascular events following a stroke by about a quarter. It is advised that anti-platelet therapy is prescribed for the

[18] NICE NG128 (2019, updated 2022) Stroke and transient ischaemic attack in over 16s http://www.nice.org.uk/guidance/ng128

secondary prevention of recurrent stroke and other vascular events in patients who have sustained an ischaemic cerebrovascular event.

ii. The British National Formulary (BNF)[19] 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)."

iii. Further information

- NICE TA210 (2010) Clopidogrel and modified-release dipyridamole for the prevention of occlusive vascular events. http://www.nice.org.uk/guidance/TA210

STIA007 Reporting and verification

i. See indicator wording for requirement criteria.

STIA014 (based on NICE IND243)

STIA014 Rationale

i. This indicator measures the intermediate outcome of a blood pressure of 140/90 mmHg or less in people aged 79 years and under who have experienced a stroke or TIA. It aims to promote the secondary prevention of cardiovascular disease through satisfactory blood pressure control. The intermediate outcome can be achieved through lifestyle advice or drug therapy subject to the caveat below.

[19] BNF stroke treatment summary. https://bnf.nice.org.uk/treatment-summary/stroke.html

ii. The NICE guideline on hypertension[20] recommends drug therapy in people aged 79 years and under with stage 1 hypertension and cardiovascular disease. Antihypertensive drug treatment is recommended for people of any age with stage 2 hypertension.

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

STIA014 Reporting and verification

i. See indicator wording for requirement criteria.

STIA015 (based on NICE IND244)

STIA015 Rationale

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

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

STIA015 Reporting and verification

i. See indicator wording for requirement criteria.

3.7 Diabetes mellitus (DM)

Indicator	Points	Thresholds
Ongoing management		

[20] NICE NG136 (2019, updated 2023) Hypertension in adults. http://www.nice.org.uk/guidance/ng136

DM006. The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs)	3	57–97%
DM012. The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 12 months	4	50–90%
DM014. The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register	11	40–90%
DM036. The percentage of patients with diabetes, on the register aged 79 years and under, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (or equivalent home blood pressure reading)	27	38-90%
DM020. The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months	17	35-75%
DM021. The percentage of patients with diabetes, on the register, with moderate or severe frailty in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months	10	52-92%

DM034. 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) or where a statin is declined or if clinically unsuitable, another lipid-lowering therapy	4	50-90%
DM035. The percentage of patients with diabetes and a history of cardiovascular disease (excluding haemorrhagic stroke) who are currently treated with a statin or where a statin is declined or if clinically unsuitable, another lipid-lowering therapy	2	50-90%

DM – rationale for inclusion of indicator set

i. Diabetes mellitus (DM) is a common endocrine disease. In 2023/24, there were approximately 3.7 million people living with diagnosed diabetes in England. Effective control and monitoring can reduce mortality and morbidity. Much of the management and monitoring of diabetes, particularly type 2 diabetes, is undertaken by the GP and members of the primary care team.

ii. Further information:

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

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

DM006 (based on NICE IND134)

DM006 Rationale

i. NICE guidelines[21],[22] recommend the use of an ACE-I (or ARBs) to slow the progression of renal disease in patients with diabetes with urine albumin: creatinine ratio (ACR) ≥3 mg/mmol. Trial evidence suggests that these are most effective when given in the maximum dose quoted in the BNF. NICE guidelines also recommend that SGLT2i should be offered or considered, depending on the level of ACR, in people with type 2 diabetes and renal disease.

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

DM006 Reporting and verification

i. See indicator wording for requirement criteria.

DM012 (based on NICE IND81)

DM012 Rationale

i. Patients with diabetes are at high risk of foot complications that could lead to ulcer, amputation or death. Evaluation and risk classification on an annual basis are important for the detection of feet most at risk.

ii. The NICE guideline on diabetic foot problems[23] outlines foot risk classification and recommends at least annual reassessment.

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

DM012 Reporting and verification

i. See indicator wording for requirement criteria.

[21] NICE NG17 (2015, updated 2022). Type 1 diabetes in adults. https://www.nice.org.uk/guidance/ng17
[22] NICE NG28 (2015, updated 2022). Type 2 diabetes in adults. https://www.nice.org.uk/guidance/ng28
[23] NICE NG19 (2015, updated 2019) Diabetic foot problems: prevention and management. http://www.nice.org.uk/guidance/NG19/

DM014 (based on NICE IND88)

DM014 Rationale

i. Diabetes is a 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 and the acquisition of relevant skills for successful self-management play an important role in achieving optimal outcomes. These needs are not always adequately 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. Structured education programmes are supported by NICE guidance[24,25].

ii. The indicator requires that SE is offered to every person with diabetes and/or their carer from the time of diagnosis. An alternative education programme of equal standard may be offered to people unable or unwilling to participate in group education sessions.

iv. There are several accredited digital education programmes including the nationally commissioned Healthy Living with type 2 diabetes. Referral to this programme will also meet the criteria for this indicator and it is available to people with type 2 diabetes and their carers at any timeframe following diagnosis, supporting annual reinforcement.

iii. This indicator suggests referral to a programme within nine months of entry onto the diabetes register to be appropriate for people with type 1 or type 2 diabetes. A timeframe of nine months for this indicator has been set to take into account the differing expectations for referral into SE programmes from diagnosis for people with type 1 and type 2 diabetes.

DM014 Reporting and verification

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

[24] NICE NG17 (2015, updated 2022). Type 1 diabetes in adults. https://www.nice.org.uk/guidance/ng17
[25] NICE NG28 (2015, updated 2022). Type 2 diabetes in adults. https://www.nice.org.uk/guidance/ng28

DM036 (based on NICE IND249)

DM036 Rationale

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

ii. Applying universal BP targets to all people with diabetes may inadvertently lead to the potential for undertreatment in those with less complex need and overtreatment in those with complex needs and co-morbidity[26]. This indicator focuses upon blood pressure management in people with diabetes without moderate or severe frailty and thus aims to reduce potential undertreatment and support better control of biomedical targets in people with the greatest capacity to benefit.

iii. Contractors should note that the BP target in this indicator is higher than that recommended in NG17 for patients with type 1 diabetes aged 79 or under with ACR of 70 mg/mmol or more, where they should be aiming for under 130/80mmHg. Contractors should use their clinical judgement when setting individual blood pressure targets, particularly for people with advanced age, living with frailty or multimorbidity.

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

DM036 Reporting and verification

i. See indicator wording for requirement criteria.

DM020 (based on NICE IND179)

DM020 Rationale

i. Glycated haemoglobin (HbA1c) is commonly used to monitor glucose control as it provides a measure of average glycaemia over the preceding 8-12 weeks. Rising levels of HbA1c increase the risk of mortality and developing macrovascular and microvascular complications. However, applying universal target levels regardless of comorbidities may inadvertently lead to over-treatment, especially in older people with

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

type 2 diabetes and people living with frailty.[27] 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 NICE guidelines[28, 29], this has been pragmatically selected as it represents the point at which people with type 2 diabetes should be considered for treatment intensification.

DM020 Reporting and verification

i. See indicator wording for requirement criteria.

DM021 (based on NICE IND180)

DM021 Rationale

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

DM021 Reporting and verification

i. See indicator wording for requirement criteria.

[27] 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.
[28] NICE NG17 (2015, updated 2022). Type 1 diabetes in adults. https://www.nice.org.uk/guidance/NG17
[29] NICE NG28 (2015, updated 2022). Type 2 diabetes in adults. https://www.nice.org.uk/guidance/NG28

DM034 (based on NICE IND275)

DM034 Rationale

i. Cardiovascular risk is elevated in people with type 1 and type 2 diabetes. The NICE guideline for cardiovascular disease risk assessment and lipid modification[30] 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. It also recommends that people with type 2 diabetes should be offered statin therapy if they have a 10% or greater 10-year risk of developing CVD, estimated using the QRISK3 assessment tool. The business rules for this indicator include clinical codes for QRISK, QRISK2, QRISK3, Framingham and Joint British Societies risk score.

ii. In 2023, the NICE guideline for cardiovascular disease: risk assessment and reduction, including lipid modification reinforced the recommendation of high-intensity statin treatment, for primary prevention (atorvastatin 20mg) and secondary prevention (atorvastatin 80mg). This indicator was updated in 2024/25 to reflect the potential for use of other lipid lowering therapies where a statin is declined or clinically unsuitable.

DM034 Reporting and verification

i. See indicator wording for requirement criteria.

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

DM035 (based on NICE IND276)

DM035 Rationale

i. The NICE guideline for cardiovascular disease risk assessment and lipid modification[31] recommends that lipid lowering treatments should be offered for the secondary prevention of CVD. For most people, this will include high intensity statin therapy, which has been shown to lower levels of low-density lipoprotein (LDL) cholesterol and is associated with a reduction in MI, coronary heart disease and

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

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

stroke. Treatment should start with atorvastatin 80mg, however there are situations in which a lower dose or alternative lipid lowering therapy should be used. This indicator This indicator was updated in 2024/25 to reflect the potential for use of other lipid lowering therapies where a statin is declined or clinically unsuitable.

DM035 Reporting and verification

i. See indicator wording for requirement criteria.

3.8 Asthma (AST)

Indicator	Points	Thresholds
Initial diagnosis		
AST012. The percentage of patients with a new diagnosis of asthma on or after 1 April 2025 with a record of an objective test between 3 months before or 3 months after diagnosis	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, a recording of the number of exacerbations, an assessment of inhaler technique and a written personalised action plan	20	45–70%

AST – rationale for inclusion of indicator set

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

AST012 (based on NICE IND272)

AST012 Rationale

i. This indicator was updated from AST011 in 2024/25 to reflect the recommendations made within the new combined asthma guideline produced by the British Thoracic Society (BTS), NICE and the Scottish Intercollegiate Guidelines Network (SIGN) in November 2024.

ii. The aim of this indicator is to encourage use of objective tests to confirm an asthma diagnosis. A combination of a suggestive clinical history and a supporting objective test is needed to diagnose asthma, with different objective testing sequences for adults, and children and young people aged 5 to 16. Improving the accuracy of diagnosis will reduce incidences of patients with untreated asthma having an asthma attack and patients who do not have asthma receiving unnecessary drugs.

iii. The guideline recommends that specific tests are used first in the sequence. The indicator allows the full range of possible tests to count as a success.

Diagnosing asthma in adults and young people (aged over 16 years) with a history suggesting asthma

i. BTS, NICE and SIGN recommend the following order in which objective tests should be carried out when diagnosing asthma in adults and young people (aged over 16 years) with a history suggestive of asthma[32]:

- Measure the blood eosinophil count or fractional exhaled nitric oxide (FeNO) level in adults and young people (aged over 16 years) with a history suggestive of asthma. Diagnose asthma if the eosinophil count is above the laboratory reference range or the FeNO level is 50 ppb or more
- If asthma is not confirmed by eosinophil count or FeNO level, measure bronchodilator reversibility (BDR)[33] with spirometry. Diagnose asthma if the FEV_1[34] increase is 12% or more and 200 ml or more from the pre-bronchodilator measurement (or if the FEV_1 increase is 10% or more of the predicted normal FEV_1)

[32] NICE NG245 (2024) Asthma: Algorithm A http://www.nice.org.uk/guidance/ng245/resources/bts-nice-and-sign-algorithm-a-summary-of-objective-tests-for-diagnosing-asthma-pdf-13556516365
[33] NICE NG245 (2024) Bronchodilator reversibility https://www.nice.org.uk/guidance/ng245/chapter/recommendations#bronchodilator-reversibility
[34] NICE NG245 (2024) FEV1 https://www.nice.org.uk/guidance/ng245/chapter/recommendations#fev1

- If spirometry is not available or it is delayed, measure peak expiratory flow (PEF)[35] twice daily for 2 weeks. Diagnose asthma if PEF variability (expressed as amplitude percentage mean) is 20% or more.
- If asthma is not confirmed by eosinophil count, FeNO, BDR or PEF variability but still suspected on clinical grounds, refer for consideration of a bronchial challenge test[36]. Diagnose asthma if bronchial hyper-responsiveness[37] is present.

Diagnosing asthma in children aged 5 to 16 with a history suggestive of asthma

i. Measure FeNO level in children and young people aged 5 to 16 years with a history suggestive of asthma. Diagnose asthma if the FeNO level is 35ppb or more. If the FeNO level is not raised or if FeNO testing is not available or not feasible, measure bronchodilator reversibility (BDR) with spirometry. Diagnose asthma if the FEV_1 increase is 12% or more from baseline (or if the FEV_1 increase is 10% or more of the predicted normal FEV_1).

ii. If spirometry is not available or it is delayed, measure peak expiratory flow (PEF) twice daily for 2 weeks. Diagnose asthma if PEF variability (expressed as amplitude percentage mean) is 20% or more.

iii. If asthma is not confirmed by FeNO, BDR or PEF variability but still suspected on clinical grounds, either perform skin prick testing to house dust mite or measure blood total IgE and blood eosinophil count.

- Exclude asthma if there is no evidence of sensitisation to house dust mite on skin prick testing or if the total serum IgE is not raised.
- Diagnose asthma if there is evidence of sensitisation or a raised total IgE and the eosinophil count is more than 0.5 x 10^9 per litre.

iv. If there is still doubt about the diagnosis, refer to a paediatric specialist for consideration of a bronchial challenge test.

Additional information

i. If an adult, young person or child aged 5 or over with a history suggestive of asthma cannot perform any objective tests, treat with inhaled steroids, review on a regular basis and try to do the tests again every 6-12 months until satisfactory results are

[35] NICE NG245 (2024) Peak expiratory flow (PEF) variability https://www.nice.org.uk/guidance/ng245/chapter/recommendations#peak-expiratory-flow-pef-variability
[36] NICE NG245 (2024) Bronchial challenge test https://www.nice.org.uk/guidance/ng245/chapter/recommendations#bronchial-challenge-test
[37] NICE NG245 (2024) Bronchial hyperresponsiveness https://www.nice.org.uk/guidance/ng245/chapter/recommendations#bronchial-hyperresponsiveness

obtained. PCAs are available for situations where the patient declines or does not attend, or if objective tests are not appropriate or feasible.

ii. In people with adult-onset asthma, poorly controlled established asthma, or reappearance of childhood asthma, NICE recommend checking for a possible occupational component and referring people with suspected occupational asthma to an occupational asthma specialist (section 1.4).

iii. NHS England is supporting systems to make objective testing, and spirometry in particular, available in the community. Commissioning standards have been produced that set out best practice in commissioning spirometry services to support systems to deliver equitable access to quality assured spirometry testing for their population across all ages[38].

If another diagnosis is more likely

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

Co-morbidity: asthma and COPD

i. A proportion of patients with asthma will have both asthma and COPD, e.g. they have airway obstruction that does not reverse to normal but also have substantial reversibility[39].

AST012 Reporting and verification

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

AST007 (based on NICE IND273)

AST007 Rationale

i. This indicator reflects the recommendations made in the new combined asthma guideline produced by NICE, BTS and SIGN in November 2024[40].

[38] NHS England (2024) Commissioning standards for spirometry https://www.england.nhs.uk/long-read/commissioning-standards-for-spirometry/
[39] NICE NG115 (2018, updated 2019) Chronic obstructive pulmonary disease in over 16s. https://www.nice.org.uk/guidance/NG115
[40] NICE NG245 (2024) Asthma: diagnosis, monitoring and chronic asthma management (BTS, NICE, SIGN). https://www.nice.org.uk/guidance/ng245

ii. This indicator covers 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, a recording of the number of exacerbations and a written personalised action plan. It measures the quality of care processes linked by evidence to improved outcomes.

iii. Annual asthma reviews can help identify people at increased risk of poor outcomes so that support can be provided based on information from their review to help them self-manage their asthma and maximise their future health. This should include, in discussion with patients, checking medicines adherence using prescription records, assessing asthma control (which could be by using a validated symptom questionnaire such as the Asthma Control Questionnaire, the Asthma Control Test or the Childhood Asthma Control Test), observing inhaler technique and checking other possible reasons for uncontrolled asthma (such as smoking, occupational exposures, and psychosocial, seasonal and environmental factors) before starting or adjusting medicines.

iv. BTS, NICE and SIGN also recommend considering actively identifying people with asthma who are at risk of poor outcomes and tailoring care to their needs (section 1.15).

v. Further detail on monitoring asthma control and developing personalised action plans, along with the importance of keeping them up to date, can be found at sections 1.5 (Monitoring asthma control) and 1.14 (self-management) of the combined guideline.

vi. The BTS, NICE and SIGN guideline also contains a number of new recommendations for the pharmacological treatment of people with asthma.

vii. Short-acting beta$_2$ agonists should not be prescribed to people of any age with asthma without a concomitant prescription of an ICS (1.6.3) and algorithms have been produced for the pharmacological management of asthma in people aged 12 years and over[41] and the pharmacological treatment of children aged 5 to 11 years[42].

viii. For those people aged 12 years and over, referral to a specialist in asthma care should be made if their asthma that is not controlled on treatment containing a high dose of ICS (1.7.11). For those aged 5-11 a referral should be made if asthma is

[41] NICE NG245 (2024) Algorithm C https://www.nice.org.uk/guidance/ng245/resources/algorithm-c-pharmacological-management-of-asthma-in-people-aged-12-years-and-over-bts-nice-pdf-13556516367
[42] NICE NG245 (2024) Algorithm D https://www.nice.org.uk/guidance/ng245/resources/algorithm-d-pharmacological-management-of-asthma-in-children-aged-5-to-11-years-bts-nice-sign-pdf-13556516368

not controlled on paediatric moderate-dose MART or paediatric moderate-dose ICS/LABA maintenance treatment (with or without an LTRA, depending on previous response) (1.8.7).

ix. PCAs are available for situations where the patient declines or does not attend, or if an annual review is not appropriate.

x. In addition to the resources provided by NICE (Tools and resources | Asthma: diagnosis, monitoring and chronic asthma management (BTS, NICE, SIGN) | Guidance | NICE), further information to support the implementation of both AST007 and AST012 can be found at:

xi. Healthcare professionals | Asthma + Lung UK,
xii. Asthma | British Thoracic Society | Better lung health for all
xiii. Asthma | Primary Care Respiratory Society
xiv. beatasthma.co.uk (for children and young people)

xv. For more information on asthma management and recommendations made to prevent deaths from asthma in the future, see the National Review of Asthma (NRAD)[43].

AST007 Reporting and verification

i. See indicator wording for requirement criteria. Children under 5 are excluded from this indicator

ii. The business rules require that contractors code the asthma review, the number of exacerbations in the month before the asthma review and the provision of a written personalised asthma plan recorded on the same day as the asthma review in order to meet the requirements of this indicator.

3.9 Chronic obstructive pulmonary disease (COPD)

Indicator	Points	Thresholds
Ongoing management		

[43] Royal College of Physicians (2016) Why asthma still kills https://www.rcp.ac.uk/improving-care/resources/why-asthma-still-kills/

COPD010. The percentage of patients with COPD on the register, who have had a review in the preceding 12 months, including a record of the number of exacerbations and an assessment of breathlessness using the Medical Research Council dyspnoea scale.	9	50–90%

COPD – rationale for inclusion of indicator set

i. Chronic obstructive pulmonary disease (COPD) describes a group of lung conditions that cause obstructive airways disease and includes chronic bronchitis and emphysema. COPD is a common disabling condition responsible for significant unscheduled healthcare utilisation. The most effective intervention is annual flu vaccination followed by tobacco dependence treatment, when applicable. Pulmonary rehabilitation has been shown to produce an improvement in quality of life and decrease exacerbations. Inhaled bronchodilators and, in some cases, inhaled corticosteroids can be of benefit.

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

COPD0010 (based on NICE IND191)

COPD0010 Rationale

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

ii. In making assessments of the patient's condition as part of an annual review and when considering management changes, it is essential that health care professionals record:

- 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.

iii. Additionally, there is evidence that inhaled therapies can improve the quality of life in some patients with COPD. However, there is evidence that patients require training in inhaler technique and that such training requires reinforcement. Where a patient is prescribed an inhaled therapy, their technique is to be assessed face to face (or by video where that's not possible) during any review.

iv. The MRC dyspnoea scale gives a measure of breathlessness and is recommended as part of the regular review. It is available in the NICE guideline on COPD, section 1.1, diagnosing COPD table one.

COPD0010 Reporting and verification

i. See indicator wording for requirement criteria.

3.10 Dementia (DEM)

Indicator	Points	Thresholds
Ongoing management		
DEM004. The percentage of patients diagnosed with dementia whose care plan has been reviewed in the preceding 12 months	14	35–70%

DEM – rationale for inclusion of indicator set

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

around 50 to 75 per cent of cases of dementia with vascular dementia accounting for up to 20 per cent[44].

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

DEM004 (based on NICE IND142)

DEM004 Rationale

i. The NICE guideline for dementia[45] recommends agreeing care plans with health and social services for people who have dementia and having formal reviews at agreed frequencies.

ii. Where a patient does not already have a care plan or an advance care plan in place, it is expected that the practice will develop a care plan.

iii. The care plan or advance care plan review should be conducted face to face or remotely in line with personal choice and should focus on supporting the needs of the patient and their carer. Regular reviews help address any changes in needs. The review, in line with NHS England's Dementia: Good personalised care and support planning guide, should cover:

- physical, mental health and social assessments
- a medication review considering use of:
  - NICE-recommended medication; cholinesterase inhibitors (CEIs) for Alzheimer's disease or dementia with Lewy Bodies or Parkinson's disease dementia, and consideration of Memantine for moderate or severe Alzheimer's disease[46]
  - any ongoing antipsychotic medication, considering current or future side effects including cardiovascular disease, diabetes and falls risk

[44] Alzheimer's Society (2020) Alzheimer's Society's view on demography. https://www.alzheimers.org.uk/about-us/policy-and-influencing/what-we-think/demography
[45] NICE NG97 (2018) Dementia. https://www.nice.org.uk/guidance/ng97
[46] NICE TA217 (2018) Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease https://www.nice.org.uk/guidance/ta217

- other prescribed medications, particularly those with anticholinergic effects[47].
- a record of the patient's:
  - named coordinator or key worker and contact details, and confirmation that they and their carer are aware of and accessing all appropriate benefits
  - legal power of attorney in place
  - end of life preferences and confirmation that they and their carers understand how to access end of life care at the appropriate time. The GP should consider whether to add the patient to the palliative care register
- a review and documentation of NICE recommended interventions offered including cognitive stimulation therapy (CST) and carer psychoeducation
- identification of the patients' carer(s) and as appropriate:
  - permissions to communicate with the carer(s) and provide details of support services, addressing the carer's need for information based on illness stage and the patient and carer's health or social care needs
  - inclusion of the carer in the care plan or advanced care plan discussions
  - the impact of caring on the carer
  - offering the carer a health check[48], including referrals to relevant services to support their health and wellbeing

v. The review should cover the above elements but be geared towards the priorities of the patient and their carer. An indicative duration of the consultation is 30 minutes[49]. Ideally, the first appointment should be within six months of diagnosis.

vi. Studies show that patients with Alzheimer-type dementia experience common physical symptoms like joint pain or infections but may not report them. Patient assessments should consider:

- behavioural changes due to physical conditions (e.g. joint pain or inter-current infections)
- new symptoms related to dementia such as wandering, delusions or hallucinations
- depression which is more common in patients with dementia than those without[50]

[47] NICE NG97 (2018) Dementia. https://www.nice.org.uk/guidance/ng97
[48] 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.
[49] 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.
[50] Alzheimer's society: Apathy, anxiety and depression. 2017

vii. Patients and carers are to be given relevant information about the diagnosis and sources of help and support whilst respecting confidentiality. Evidence suggests that healthcare professionals can improve satisfaction for carers by acknowledging carers' distress and providing more supporting information[51]. As the illness progresses, needs may change, and the review may focus more on issues such as respite care.

viii. There is good evidence from 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.

ix. As the illness progresses and more agencies are involved, the review should assess 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 need to be followed up as part of the review process.

Further information:

- NICE NG97 (2018) Dementia. https://www.nice.org.uk/guidance/ng97
- NICE QS184 (2019) Dementia. https://www.nice.org.uk/guidance/qs184
- Forget me not dementia training. http://www.forgetmenotdementia.co.uk/
- NSF for Older People (2001) http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_4003066
- NICE PH16 (2008) Mental wellbeing in over 65s: occupational therapy and physical activity interventions. https://www.nice.org.uk/guidance/ph16
- NHS Choices. Looking after someone with dementia. 2015. https://www.nhs.uk/conditions/dementia/carers/

DEM004 Reporting and verification

i. See indicator wording for requirement criteria.

[51] Eccles et al. BMJ 1998; 317: 802-808

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

3.11 Mental health (MH)

Indicator	Points	Thresholds
Ongoing management		
MH002. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate	5	40–90%
MH003. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months	3	50–90%
MH006. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months	3	50-90%
MH007. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months	3	50-90%
MH011. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of a lipid profile in the preceding 12 months (in those patients currently prescribed antipsychotics, and/or have pre-existing cardiovascular conditions, and/or smoke, and/or are overweight (BMI of ≥23 kg/m2 or ≥25 kg/m2 if	7	50-90%

ethnicity is recorded as White) or preceding 24 months for all other patients		
MH012. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months	7	50-90%

MH – rationale for inclusion of indicator set

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

ii. For many patients with mental health problems, the most important aspects of care quality relate to the interpersonal skills of the doctor, the time given in consultations and the opportunity to discuss a range of management options.

iii. An important aim of the indicator set is to help address a major health inequality experienced by people with severe mental illness (SMI) reflected in a reduced life expectancy of around 15-20 years[52]. This disparity is largely due to preventable physical illnesses. People with SMI develop chronic physical health conditions at a younger age than people without SMI. These chronic conditions include obesity, asthma, diabetes, chronic obstructive pulmonary disease, coronary heart disease, stroke, heart failure and liver disease. People with SMI are at increased risk of developing more than one of these chronic conditions[53].

iv. NICE CG178[54] recommends that primary care utilise registers to monitor the physical health of patients with psychosis or schizophrenia. The health check should be comprehensive, focusing on physical health problems that are common in people with psychosis and schizophrenia. NICE recommends health checks should include the following:

[52] Public Health England (2018) Severe mental illness (SMI) and physical health inequalities: briefing. https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities/severe-mental-illness-and-physical-health-inequalities-briefing
[53] Office for Health Improvement & Disparities (2023) Premature mortality in adults with severe mental illness (SMI) https://www.gov.uk/government/publications/premature-mortality-in-adults-with-severe-mental-illness/premature-mortality-in-adults-with-severe-mental-illness-smi
[54] NICE CG178 (2014) Psychosis and schizophrenia in adults. http://www.nice.org.uk/guidance/CG178

- weight (plotted on a chart)
- waist circumference
- pulse and blood pressure
- fasting blood glucose or glycosylated haemoglobin (HbA1c)
- blood lipid profile and prolactin levels
- assessment of any movement disorders
- assessment of nutritional status, diet and level of physical activity

v. NICE CG185[55] recommends that patients with bipolar affective disorder have a physical health review, normally in primary care, performed at least annually, including:

- weight or BMI, diet, nutritional status and level of physical activity
- cardiovascular status, including pulse and blood pressure
- metabolic status, including glycosylated haemoglobin (HbA1c) and blood lipid profile
- liver function
- renal and thyroid function, and calcium levels, for people taking long-term lithium

vi. A key focus of the SMI annual health check is to identify those individuals with risk factors (including metabolic syndrome) for cardiovascular disease (CVD) and type 2 diabetes, given these disorders are 2-3x more common than in the general population and are major contributors to the life expectancy gap.[56]. Clustering of risk factors (obesity, hypertension, glucose and lipid disturbances) are caused by the accumulative effect of adverse metabolic effects from psychotropic medication and poor health behaviours (poor diet, physical inactivity).[57] Risk is further compounded by substantially higher rates of smoking than in the general population.[58] A full annual check and supported signposting to appropriate interventions is therefore important for reducing risk.

[55] NICE CG185 (2014, updated 2023) Bipolar disorder: assessment and management. http://www.nice.org.uk/guidance/CG185
[56] Ma R, Romano E, Ashworth M, Yadegarfar ME, Dregan A, Ronaldson A, de Oliveira C, Jacobs R, Stewart R, Stubbs B. Multimorbidity clusters among people with serious mental illness: a representative primary and secondary data linkage cohort study. Psychol Med. 2023 Jul;53(10):4333-4344. doi: 10.1017/S003329172200109X.)
[57] Vancampfort D, Stubbs B, Mitchell AJ, De Hert M, Wampers M, Ward PB, Rosenbaum S, Correll CU. Risk of metabolic syndrome and its components in people with schizophrenia and related psychotic disorders, bipolar disorder and major depressive disorder: a systematic review and meta-analysis. World Psychiatry. 2015 Oct;14(3):339-47
[58] Szatkowski L, McNeill A. Diverging trends in smoking behaviors according to mental health status. Nicotine Tob Res 2014; 17: 356–60.

Further information

- NICE CG178 (2014) Psychosis and schizophrenia in adults. https://www.nice.org.uk/guidance/cg178

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

MH002 (based on NICE IND143)

MH002 Rationale

i. This indicator reflects good professional practice and is supported by NICE CG178[59] and CG185[60].

ii. Patients on the mental health disease register should have a documented primary care consultation that acknowledges, especially in the event of a relapse, a care plan, including considering the views of relative(s) or carer(s) where appropriate.

iii. For patients that are discharged from secondary care, it is important that the primary care team takes responsibility for discussing and documenting a care plan in their primary care record.

iv. If a patient is treated within community mental health services and has a documented care plan, this is acceptable for the purposes of QOF provided the practice has evidence of a review having taken place[61].

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

MH002 Reporting and verification

i. See indicator wording for requirement criteria.

[59] NICE CG178 (2014). Psychosis and schizophrenia in adults. http://www.nice.org.uk/guidance/CG178
[60] NICE CG185 (2014, updated 2023) Bipolar disorder. https://www.nice.org.uk/guidance/cg185
[61] Community Mental Health Framework replaced CPA. https://www.england.nhs.uk/publication/care-programme-approach-position-statement/

ii. Verification – Commissioners may require contractors to randomly select a number of care plans to ensure that they are being reviewed annually and updated where necessary.

MH003, MH006, MH007, M011 and MH012 (based on NICE IND84, IND83, IND82, IND158, IND159 respectively)

MH003, MH006, MH007, M011 and MH012 Rationale

i. NICE guidance[62,63] recommends annual monitoring of blood pressure for people with bipolar disorder, psychosis or schizophrenia. A prospective record linkage study of the mortality of a community cohort of 370 patients with schizophrenia found that the increased mortality risk is probably life-long and it suggested that the cardiovascular mortality of people with schizophrenia has increased over the past 25 years relative to the general population[64]. 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.

iii. While disturbances such as impaired glucose tolerance and diabetes, hypertension, and dyslipidaemia tend to emerge around middle age in the general population, in people with SMI they may be detectable from as early as the first presentation. This helps to explain why cardiovascular risk prediction tools developed primarily for the general population underestimate risk in young people with SMI[65],[66].

iv. Recording (and treating) cardiovascular risk factors is therefore very important for patients with a severe mental illness.

v. MH007 incentivises delivering the requirement to record alcohol intake as part of the physical check. Alcohol and other substance misuse by people with schizophrenia is increasingly recognised as a major problem, both in terms of its prevalence and its clinical and social effects[67]. The National Psychiatric Morbidity Survey in England

[62] NICE CG178 (2014). Psychosis and schizophrenia in adults. http://www.nice.org.uk/guidance/CG178
[63] NICE CG185 (2014, updated 2020) Bipolar disorder. https://www.nice.org.uk/guidance/cg185
[64] Brown S, Kim M, Mitchell C et al. 25 year mortality of a community cohort with schizophrenia. BJP. 2010. 196: 116-21.
[65] Perry BI, McIntosh G, Weich S, et al. The association between first-episode psychosis and abnormal glycaemic control: systematic review and meta-analysis. Lancet Psychiatry 2016; 3(11): 1049–1058.
[66] Perry BI, Upthegrove R, Crawford O, et al. Cardiometabolic risk prediction algorithms for young people with psychosis: a systematic review and exploratory analysis. Acta Psychiatrica Scand 2020; 142(3): 215–232.
[67] 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.

found that 16% of people with schizophrenia were drinking above the lower risk consumption levels (14 units) of alcohol[68,69]. Bipolar affective disorder is also highly co-morbid with alcohol and other substance abuse.

vi. NICE guidance[70,71] recommends annual monitoring of blood glucose or HbA1c for people with bipolar disorder, psychosis or schizophrenia. Diabetes is 2–3 times more common among people with SMI than the general population[72] and antipsychotic medication can be diabetogenic[73]. People with SMI are more likely to develop type 2 diabetes earlier than the general population, frequently in the fourth and fifth decades.

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

i. See indicator wording for requirement criteria.

ii. Within the business rules currently being prescribed an antipsychotic medication is defined as a prescription in the preceding 6 months; pre-existing cardiovascular conditions are defined as CHD, diabetes, stroke, peripheral arterial disease and chronic kidney disease; being a current smoker is defined as a patient whose notes record smoking status in the preceding 12 months and being overweight is defined as latest BMI of ≥ 23 kg/m2 or ≥25 kg/m2 if ethnicity is recorded as white.

iii. Patients who have a diagnosis of diabetes will be excluded from MH012.

3.12 Non-diabetic hyperglycaemia (NDH)

Indicator	Points	Thresholds
Records		

[68] 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.
[69] 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.
[70] NICE CG178 (2014). Psychosis and schizophrenia in adults. http://www.nice.org.uk/guidance/CG178
[71] NICE CG185 (2014, updated 2020) Bipolar disorder. https://www.nice.org.uk/guidance/cg185
[72] Holt, R. I., & Mitchell, A. J. (2015). Diabetes mellitus and severe mental illness: mechanisms and clinical implications. Nat Rev Endocrinol, 11(2), 79-89. https://doi.org/10.1038/nrendo.2014.203
[73] Smith M, Hopkins D, Peveler RC, et al. (2008) First-v. second-generation antipsychotics and risk for diabetes in schizophrenia: systematic review and meta-analysis. Br J Psychiatry 192(6):406–411.

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

NDH – rationale for inclusion of indicator set

vii. NDH (also known as prediabetes) is defined as an HbA1c of 42-47mmol/mol or a fasting plasma glucose (FPG) of 5.5-6.9mmol/l[74]. There were more than 3.7 million people with NDH in England in 2023/24, representing an increase of 530,000 people compared with the previous year.

i. The NHS has invested significantly in behavioural interventions for those with NDH in order to prevent and delay the onset of type 2 diabetes. The Healthier You: NHS Diabetes Prevention Programme (NHS DPP) is the largest undertaking of its kind in the world and over 840,000 people have participated since its introduction in 2016. An independent evaluation of the programme has demonstrated its effectiveness, with programme completion (defined as attending >60% of sessions) associated with a relative risk reduction of 37% for the development of type 2 diabetes.

ii. The NHS DPP is available across the whole of England, and GP practices can refer patients aged 18 or over with a blood test result demonstrating NDH in the 12 months prior to referral. Individuals with a history of Gestational Diabetes Mellitus (GDM) are also eligible and have an additional route of accessing the programme through self-referral. Participants of the NHS DPP must not be pregnant, have ever been diagnosed with type 2 diabetes, be recorded as living with moderate/severe frailty, have an active eating disorder or have had bariatric surgery within the previous 2 years.

NDH002 (based on NICE IND172)

NDH002 Rationale

i. NICE Guidance (PH38[75]) recommends that everyone with NDH is offered an annual blood test to check for progression to Type 2 diabetes. Despite this, there is wide variation in the monitoring of people with NDH.

[74] NICE PH38 (2012, updated 2017) Type 2 diabetes: prevention in people at high risk http://www.nice.org.uk/guidance/ph38
[75] NICE PH38 (2012, updated 2017) Type 2 diabetes: prevention in people at high risk http://www.nice.org.uk/guidance/ph38

ii. The aim of this indicator is to promote early identification if people progress from having NDH to type 2 diabetes, as early recognition and management of diabetes is associated with improved long-term outcomes. Criteria for diagnosing diabetes are discussed in the diabetes section of this guidance.

NDH002 Reporting and verification

i. See indicator wording for requirement criteria.

ii. The register for the purpose of calculating the APDF is defined as all patients aged 18 or over with a record of non-diabetic hyperglycaemia or pre-diabetes, which has not been superseded by a diagnosis of diabetes recorded prior to the beginning of the financial year.

4. Public health domain

4.1 Blood pressure (BP)

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

BP002 (based on NICE IND112)

BP002 Rationale

i. Detecting elevated blood pressure and, where indicated, treating it, is known to be an effective health intervention. Raised blood pressure is common if it is measured on a single occasion but with repeated measurement blood pressure tends to drop. NICE guideline recommendations for the diagnosis and treatment of hypertension[76] are to be followed by practitioners when deciding on whether to treat raised blood pressure.

ii. The age limit of aged 45 or over has been chosen as the vast majority of patients develop hypertension after this age. The age range 45 or over, coupled with a five-year reference period is in line with the NHS Health Checks Scheme, which starts at 40 years old. It is also to align the indicator more closely with the vascular checks

[76] NICE NG136 (2019, updated 2023) Hypertension in adults http://www.nice.org.uk/guidance/ng136

programme and the cost-effectiveness modelling undertaken to support that programme.

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

BP002 Reporting and verification

i. See indicator wording for requirement criteria.

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

4.2 Smoking (SMOK)

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

SMOK – rationale for inclusion of indicator set

i. Smoking has been identified as the top modifiable risk factor for morbidity and premature death in England[77]. In England, adult smoking prevalence is 11.6%[78]. with 7.4% of pregnant women smoking at the time of delivery[79]. However, rates are higher in most deprived populations with 17.2% of people smoking in the most deprived IMD decile[80], over 25% for people with a long-term mental health condition[81] and higher still for people with a severe mental illness[82]. Smoking causes or exacerbates over 100 conditions, including cancers, respiratory disease, cardiovascular disease, depression, psychosis and schizophrenia[83]. Smoking during pregnancy can cause serious pregnancy related health problems, these include complications during labour and an increased risk of miscarriage, premature birth, still birth, low birth weight and sudden unexpected death in infancy[84] and has a detrimental impact on infancy through to childhood[85].

ii. The aim of this domain is to increase the proportion of successful smoking quit attempts by providing the best available treatment. There is good evidence to suggest that offering support and treatment is sufficient to motivate some smokers to attempt to stop who would not have done so with brief advice to quit alone.

iii. 'An offer of treatment' means offering a referral to a local Stop Smoking Service adviser (who might be a member of the practice team) plus pharmacotherapy. Where such treatment is not acceptable to the patient, an alternative form of brief support, such as follow-up appointments with a GP or practice nurse trained in smoking cessation, may be offered.

[77] Global Burden of Disease data https://www.healthdata.org/research-analysis/health-by-location/profiles/united-kingdom-england#main-content
[78] Office for National Statistics (2023) Adult smoking habits in the UK: 2023 https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/adultsmokinghabitsingreatbritain/2023
[79] NHS Digital Statistics on Women's Smoking Status at Time of Delivery: England https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-women-s-smoking-status-at-time-of-delivery-england
[80] Office for National Statistics (2023) Deprivation and the impact on smoking prevalence, England and Wales: 2017 to 2021 https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/drugusealcoholandsmoking/bulletins/deprivationandtheimpactonsmokingprevalenceenglandandwales/2017to2021
[81] Department of Health and Social Care Smoking Profile – Data https://fingertips.phe.org.uk/profile/tobacco-control
[82] National Library of Medicine (2019) Smoking cessation for people with severe mental illness (SCIMITAR+): a pragmatic randomised controlled trial https://pubmed.ncbi.nlm.nih.gov/30975539/
[83] Hiding in plain sight: Treating tobacco dependency in the NHS | RCP London, RCP Hiding in Plain Sight Report, 2018.
[84] Hiding in plain sight: Treating tobacco dependency in the NHS | RCP London, RCP Hiding in Plain Sight Report, 2018.
[85] Passive smoking prelims, Tobacco Advisory Group of the Royal College of Physicians, March 2010

iv. The NICE guidance on tobacco[86] identifies the evidence-based interventions for adults who smoke:

- behavioural support (individual and group)
- very brief advice
- bupropion[87]
- nicotine replacement therapy (NRT) – short and long acting
- varenicline[88]
- Cytisinicline (cytisine)
- nicotine-containing e-cigarettes

v. Due to the potential for ex-smokers to resume smoking within three years of cessation, it is good clinical practice to ask patients with a history of smoking their current smoking status and offer treatment and advice where necessary. It is also good practice to ask and record the smoking status of newly registered patients and to offer support and treatment where necessary.

SMOK002 (based on NICE IND97)

SMOK002 Rationale

i. See rationale above.

SMOK002 Reporting and verification

i. See indicator wording for requirement criteria.

ii. The disease register for the purpose of calculating APDF for SMOK002 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.

iii. The contractor should report smoking status using the following guidance:

[86] NICE NG209 (2021, updated 2023 and 2025) Tobacco: preventing uptake, promoting quitting and treating dependence. https://www.nice.org.uk/guidance/ng209
[87] See information on bupropion hydrochloride in the British national formulary.
[88] See information on varenicline in the British national formulary.

1. Smokers

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

2. Non-smokers

i. It is recognised that life-long non-smokers are very unlikely to start smoking and repeatedly asking smoking status can be unnecessary. Smoking status for this group of patients should be recorded in the preceding 12 months until the end of the financial year in which the patient reaches the age of 25.

ii. Once a patient is over the age of 25 years (e.g. in the financial year in which they reach the age of 26 or in any year following that financial year) to be classified as a non-smoker they should be recorded as:

- Never smoked which is both after their 25th birthday and after the earliest diagnosis date for the disease which led to the patient's inclusion on the SMOK002 register (e.g. one of the conditions listed on the SMOK002 register).

3. Ex-smokers

i. Ex-smokers can be recorded as such in the preceding 12 months for SMOK002. Practices may choose to record ex-smoking status on an annual basis for three consecutive financial years and after that smoking status need only be recorded if there is a change. This is to recognise that once a patient has been an ex-smoker for more than three years, they are unlikely to restart.

ii. For the purposes of QOF, users of electronic cigarettes who have never smoked or given up smoking should be classified as non-smokers or ex-smokers respectively.

SMOK004 (based on NICE IND99)

SMOK004 Rationale

i. See rationale above.

SMOK004 Reporting and verification

i. See indicator wording for requirement criteria.

ii. There is no APDF calculation for SMOK004.

4.3 Vaccination and immunisations (VI)

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

VI – rationale for inclusion of indicator set

i. Vaccination currently prevents 2-3 million deaths worldwide every year[89]. 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[90].

Note on vaccinations delivered overseas

i. Where a patient has been vaccinated overseas in accordance with the UK National Vaccination Schedule (i.e. the schedule of the overseas country conforms to the UK schedule) practices can record delivery of the vaccination in their clinical system to

[89] https://www.who.int/en/news-room/fact-sheets/detail/immunization-coverage
[90] https://www.who.int/news-room/spotlight/ten-threats-to-global-health-in-2019

ensure that the vaccination counts towards QOF achievement. For avoidance of doubt, if a patient has been vaccinated overseas in accordance with the UK national schedule and appropriate evidence has been provided of this vaccination event, the patient should count as a success in respect of any relevant QOF indicator – it should not simply trigger a Personalised Care Adjustment.

ii. When a patient or their representative reports that a vaccination has been delivered overseas or in another setting, individual clinicians should exercise their judgement to determine that a vaccination has been delivered and to record it in the patient record. The Green Book states, "If children and adults coming to the UK do not have a documented or reliable verbal history of immunisation, they should be assumed to be unimmunised and a full course of required immunisations should be planned." Patients arriving from overseas with a "documented or reliable verbal history of immunisation" can be assumed to be immunised and recorded as such in the GP patient record – though in the case of reliable verbal histories, it may not be possible to record the batch number or exact vaccination date.

iii. Where a patient has been vaccinated overseas in accordance with the UK national schedule, the practice can ensure that the vaccination counts towards QOF achievement but does not attract an item of service payment by coding the vaccination event in the following way:

iv. Backdate the event date of the vaccination SNOMED code to accurately reflect when the vaccination was delivered.

v. Set the GMS flag to 'No' (for EMIS and Cegedim practices) or the 'Event done' flag to 'No' (for TPP practices).[91]

vi. If the vaccination is for MMR or Shingles, use the "MMR vaccination given by other healthcare provider" or "Shingles vaccination given by other healthcare provider" SNOMED code.[92]

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

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

vii. Add free text associated with the vaccination SNOMED code to note the date the vaccine was given and where.

Note on automated Personalised Care Adjustment (PCA)

iii. PCA is available for VI001, VI002 and VI003 to take into account patients who registered at the practice too late (either too late in age, or too late in the financial year) to be vaccinated in accordance with the UK national schedule (or, where they differ, the requirements of the relevant QOF indicator).

iv. The PCA is built into the business rule logic underpinning the QOF V&I GPES extracts and applies in circumstances where a child is registered with a practice and:

1. there is insufficient time to provide any incomplete vaccinations either within the required timeframes to meet the indicator requirements, or
2. where a child has an incomplete vaccination status and is now older than the cut-off age required by the indicator.

iii. The PCA cannot be applied manually and will be automatically applied by the indicator logic. The PCA will be superseded in the extract logic by success (i.e. the relevant vaccinations being given before the relevant cut-off age required by the indicators). The PCA applies once the individuals are registered with the practice and the relevant logic parameters are met. Where the PCA is applied, it will remove the child from both the denominator and numerator thus not impacting on achievement of the relevant indicator.

iv. In the event a child is registered with a practice and has already reached the relevant indicator's cut off age - where the cut off age is 8 months for VI001, 18 months for VI002 and 5 years for VI003 - and had incomplete vaccinations, then the automatic PCA will be applied. This is because it is by no fault of the practice that this child was not vaccinated.

v. However, for a child that is registered with a practice at an age younger than the cut off age for the relevant indicator, then the PCA is flexibly applied depending on both the time remaining prior to the child reaching the cut off age and the number of outstanding doses. A timeframe of 31 days per outstanding dose from registration

date to meeting the cut off age for the indicator is applied. Further information can be found in the business rules[93].

vi. Practices may want to check whether this PCA is active on the system by using the various system reporting tools such as 'How am I driving?' before the end of the financial year.

vii. Some examples of how the new PCA applies to the three V&I indicators are provided below:

For VI001.

i. If a child is registered with a practice on or after 7 months of age and has two or fewer doses of diphtheria, tetanus and pertussis containing vaccine prior to registering then the PCA would automatically be applied as there would be insufficient time to offer and administer the required doses.

ii. If a child is registered with a practice on or after 6 months of age and has one or no doses of diphtheria, tetanus and pertussis containing vaccine prior to registering then the PCA would automatically be applied as there would be insufficient time. However, if a child registered with the practice at 6 months of age and had already had two doses of diphtheria, tetanus and pertussis containing vaccine prior to registering and the third dose was not given by the practice before the child turns 8 months, then the practice would not achieve the indicator for this specific child – this is because the practice would have had sufficient time to give the remaining dose.

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

iv. If a child registered with a practice between 1-4 months of age and had no doses of diphtheria, tetanus and pertussis containing vaccine prior to registering and the

[93] NHS England (2025) Quality and Outcomes Framework (QOF) business rules https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/quality-and-outcomes-framework-qof/business-rules

practice does not give all three doses before the child turns 8 months old, then the practice would not achieve the indicator for this specific child. The automated PCA would not apply.

For VI002.

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

For VI003.

i. If a child registered with a practice on or after 4 years and 11 months of age and had either (1) two MMR vaccinations but no booster DTap/IPV or (2) only one MMR and the booster DTap/IPV, then the automatic PCA will be applied as there is insufficient time.

ii. If a child registered with a practice on or after 4 years and 10 months of age and had either (1) only had one MMR and no booster DTap/IPV or (2) no MMR but had the booster DTap/IPV, then the automatic PCA will be applied as there is insufficient time.

iii. If a child registered with a practice on or after 4 years and 9 months of age and had no MMR vaccinations and no booster DTap/IPV, then the automatic PCA will be applied as there is insufficient time.

iv. If a child registered with a practice younger than 4 years and 9 months of age and does not receive both MMR vaccinations and the booster DTap/IPV then the practice would not achieve the indicator for this specific child.

VI001 (based on NICE IND215)

VI001 Rationale

i. Diphtheria, tetanus and pertussis (whooping cough) are acute infectious diseases that can have severe complications. The routine immunisation schedule states that the hexavalent (6-in-1) vaccine is due at 8, 12 and 16 weeks old for immunisation to

diphtheria, tetanus and pertussis (DTaP) as well as poliomyelitis (IPV), haemophilus influenzae type B (Hib) and hepatitis B[94].

ii. The indicator supports early vaccination according to the routine immunisation schedule. Measurement by 8 months old allows for vaccination deferral due to febrile illness but aims to achieve immunisation against the named acute infectious diseases as early as possible.

VI001 Reporting and verification

i. See indicator wording for requirement criteria.

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

VI002 (based on NICE IND216)

VI002 Rationale

i. MMR is the combined vaccine that protects against measles, mumps and rubella. These are highly infectious conditions that can have serious complications such as meningitis and encephalitis. The first MMR vaccine (MMR1) is due as part of the routine vaccination schedule for England within a month of the child's first birthday[95].

ii. The indicator supports early vaccination with the first dose of the MMR vaccine according to the routine immunisation schedule. Measurement by 18 months old allows for vaccination deferral due to febrile illness but aims to achieve vaccination as early as possible.

VI002 Reporting and verification

i. See indicator wording for requirement criteria.

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

[94] UK Health Security Agency (2025) Complete routine immunisation schedule https://www.gov.uk/government/publications/the-complete-routine-immunisation-schedule
[95] UK Health Security Agency (2025) Complete routine immunisation schedule https://www.gov.uk/government/publications/the-complete-routine-immunisation-schedule

VI003 (based on NICE IND217)

VI003 Rationale

i. The indicator supports immunisation according to the routine immunisation schedule. Measurement by 5 years old aims to achieve full immunisation against these infectious diseases before children start school.

VI003 Reporting and verification

i. See indicator wording for requirement criteria.

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

VI004 (based on NICE IND219)

VI004 Rationale

i. Shingles is caused by the reactivation of a latent varicella zoster virus infection. Incidence and severity of disease are associated with increasing age. The routine immunisation schedule states that since September 2023 the shingles vaccine should be offered to those turning 65 years of age and those aged 70 to 79[96]. Patients remain eligible for the vaccination until their 80th birthday.

ii. The indicator supports vaccination against shingles for patients 70 years old and over. The effectiveness of the shingles vaccine decreases with increasing age so earlier vaccination is encouraged to ensure optimal protection against shingles.

VI004 Reporting and verification

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

[96] UK Health Security Agency (2025) Complete routine immunisation schedule https://www.gov.uk/government/publications/the-complete-routine-immunisation-schedule

Public health domain – additional services

For contractors providing additional services the following indicators apply.

4.4 Cervical screening (CS)

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

CS indicator 005 (based on NICE IND176)

CS indicator 006 (based on NICE IND177)

CS005 and CS006 Rationale

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

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

iii. During 2025/26 it is anticipated that the NHS Cervical Screening Programme will deliver further transformational change projects that would be expected to support Practices in their efforts to achieve QOF indicators. Once confirmed, further guidance will be made available on the NHS Cervical Screening professional guidance pages[97] on GOV.UK.

[97] https://www.gov.uk/government/collections/cervical-screening-professional-guidance#programme-pathway

CS005 and CS006 Reporting and verification

i. See indicator wording for requirement criteria.

ii. Commissioners may require that the contractor can provide a computer print-out showing the number eligible on the contractor list, the number with a personalised care adjustment and the number who have had a cervical screening test performed at the appropriate time interval.

iii. Women and people with a cervix eligible should be sent a minimum of three invitations before the personalised care adjustment of not responding to invitations for care can be applied as described in Section 6 of this guidance. The first two invitations are sent by the national call/recall service. The third should be sent by the contractor. There is a discrete SNOMED code to record those who have not responded to three invitations for cervical screening.

5. Personalised care adjustments

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

- *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).
- *Newly diagnosed or newly registered* patients, as per existing rules.

ii. As with exception reporting applying a PCA to the patient record will remove that patient from an indicator denominator if the QOF defined intervention has not been delivered. It will not result in patients being removed from the disease register or other target population.

iii. This mechanism differs from ‘exclusions’ which refer to patients on a particular clinical register who are not included in an indicator denominator for definitional reasons. For example, an indicator (and therefore the denominator) may refer only to patients of a

specific age group, patients with a specific status (e.g. those who smoke), or patients with a specific length of diagnosis, within the register for that clinical area.

Principles

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

1. The duty of care remains for all patients.
2. The decision to apply a personalised care adjustment should be based on clinical judgement, informed by patient preferences and underpinned by shared decision-making principles, with clear and auditable reasons coded or entered in free text on the patient record.
3. There should be no blanket personalised care adjustments: the relevant issues with each patient should be considered by the clinician at each level of the clinical indicator set and this decision should be reviewed on a regular basis.
4. In each case where a personalised care adjustment is applied, in addition to what needs to be reported for payment purposes (in accordance with the business rules), the contractor should also ensure that the reason for the adjustment is fully recorded in a way that can facilitate both safe and effective patient care and audit of the patient record. For example, where a patient has not tolerated medication, the nature of the contraindication should be recorded in the patient's record as well as a code to indicate intolerance.

Criteria for the personalised care adjustment

i. Personalisation of care can occur for the following reasons which are listed in the order in which they will be extracted in the business rules:

1. The investigative service or secondary care service is unavailable (where relevant to the indicator).
2. Intervention described in the indicator is clinically unsuitable.
3. The patient has chosen not to receive the intervention described in the indicator.
4. The patient has not responded to invitations for the intervention described in the indicator (a minimum of two invitations for the intervention in the preceding 12 months, except for the cervical screening indicators, where women should receive a total of three invitations for screening).

5. The patient has registered with the practice or has been newly diagnosed with the condition of interest in the preceding 3 months and has not received the defined clinical measurements (e.g. blood pressure measurement).

6. The patient has registered with the practice or has been newly diagnosed with the condition of interest in the preceding 9 months and has not achieved the defined clinical standards (e.g. blood pressure control within target levels).

ii. The PCAs used for each indicator are detailed in the business rules.

iii. It is recognised that patients may meet more than one of these criteria and in these circumstances all reasons for personalisation should be recorded in the patient's record to facilitate safe and effective patient care. However, as a patient can only be acknowledged as having a personalised care adjustment once within the business rules for a given indicator, they will be allocated to the first criterion they meet in the hierarchy listed above. For example, where a patient is recorded as having registered with the practice in the preceding 3 months and has also chosen not to receive the intervention described in the indicator, they would be identified in the business rules as having chosen not to receive the care.

iv. The hierarchy listed above seeks to priorities clinical judgement and patient choice over other criteria. Applying this hierarchy consistently in the business rules in conjunction with the recording changes described below will support better attribution of the reason for care being personalised, allowing for more meaningful conversations between clinicians, commissioners and regulators.

Interpretation and recording of the personalised care adjustment

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

The investigative service or secondary care service is unavailable

i. This personalised care adjustment will apply only to indicator DM014.

ii. Where one of these services is unavailable, this should be recorded using specific codes which state that the service is unavailable. The contractor is expected to explore fully with their ICB if a suitable investigative or secondary service could be commissioned for the patient prior to entering a 'service unavailable' code in the patient record.

iii. The frequency with which ‘service unavailable’ codes should be added to the patient record is noted below and may vary between indicators. Some codes may need to be entered annually, whereas others may only need to be entered once in the relevant timeframe stated in the indicator.

Table 2: Frequency of data entry

Indicator ID	Service unavailable may be recorded
DM014	Within 279 days of diagnosis of diabetes

Intervention described in the indicator is clinically unsuitable

i. We envisage this being the main reason for personalisation of care, recognising the importance of clinical judgement in determining the applicability of guideline recommendations to individual patients.

ii. This category encapsulates the historical exception reporting criteria of 1) patients for whom it is not appropriate to review their chronic disease parameters due to particular circumstances (e.g. receiving end of life care), 2) those who are on maximal tolerated doses of medication, 3) those who have an allergy, contraindication or adverse reaction to medication, 4) those who have not tolerated medications and 5) where the patient has a supervening condition which would make treatment of their condition inappropriate.

iii. This criterion will be supported by both generic ‘patient unsuitable’ codes which will apply to all indicators in the clinical area except for indicators VI001, VI002 and VI003) and more specific codes which can be attributed to single indicators. Indicators in the Vaccination and Immunisation domain will be supported by specific codes for clinical unsuitability for a vaccination. Over time, more specific codes will be introduced which define the clinical reasons which might make the intervention clinically unsuitable for an individual patient.

iv. Codes which indicate ongoing and permanent reasons for personalisation of care such as allergies to specified medication may be entered once in the medical record. Other codes will need to be recorded on an annual basis following an individual patient review of the applicability of the intervention described in the indicator.

v. It is not acceptable to exclude all patients who are under the care of a consultant. Each case needs to be carefully considered and all reasonable efforts made to provide optimal care.

vi. Even when a patient is under the care of a consultant only, the contractor should ensure it has evidence that all the requirements of the contract have been carried out. If this evidence is not available, the contractor should assume that the action has not been carried out and either fulfil the requirements of the relevant indicator(s) or obtain evidence from secondary care that the particular test/check has been carried out. Where the secondary care clinician, in agreement with the primary care clinician, has exercised clinical judgement and decided further action or testing is inappropriate, this should be noted in the patient record. A personalised care adjustment may then be applied.

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

i. This criterion requires that there has been a personal contact or a discussion recorded in the patient record which ideally notes the reasons for the intervention being declined. This contact may be face-to-face or through video conferencing or telephone contact between a health professional and the patient.

ii. This criterion will be supported by both generic ‘informed dissent’ codes which will apply to all indicators in the clinical area and more specific codes which can be attributed to single indicators. Practices are encouraged to use more specific codes where they are available.

iii. The decision to decline a QOF intervention should be reviewed with the patient on an annual basis and recorded annually if necessary. The exceptions to this are indicators CS005 and CS006 where the choice not to receive the intervention need only be entered once during the time-period stated in the indicator. However, as noted in the underpinning principles, good practice would be to revisit this decision on a regular basis. Women who choose to withdraw from the cervical screening call/recall will receive no further offers of screening from the central screening service.

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

i. To be removed from an indicator denominator using this criterion patients must have been sent a minimum of two invitations for QOF care at two unique time points in the QOF year (i.e. 1 April to 31 March) separated by a minimum of seven calendar days.

The exceptions to this are indicators CS005 and CS006 where the patient should have been sent a minimum of three invitations at three unique time points during the timeframe stipulated in the indicator. However, care should continue to be offered on an opportunistic basis where appropriate.

General standards and recording requirements for invitations

i. Many different methods of communication are already available to invite patients for QOF care and these are likely to expand with the ongoing development of digital technology. The NHS also has a legal duty to ensure that patients who have a disability, impairment or sensory loss get information that they can access and understand as set out in the Accessible Information Standard[98]. The first step to making an effective invitation for care therefore is that it is made in a manner which is accessible to the patient. Therefore, practices should prospectively and opportunistically record individual patients preferred methods of communication, for example at the time of the next patient contact. Where a preferred contact method is recorded, this would be used to make the first invitation for care. The second invitation may be via any method.

ii. All invitations should be personalised to the patient (i.e. use their name and specify what they are being invited for). Where invitations are being sent via letter or email these should also include information for the patient as to why this care is being offered and its importance for their health care.

iii. Invitations should be coded at the time they are sent to the patient. For data extraction purposes, there should be a minimum of seven calendar days between each invitation, but practices should use their judgement in determining the optimal spacing between invitations for their practice population. A longer period may be more appropriate. Codes currently exist to indicate the communication method used to make the invitation and that the patient's preferred method was used. Both will be acceptable for QOF purposes.

iv. Patients should be sent a minimum of two invitations for care within the QOF year (i.e. 1 April – 31 March). If these invitations are correctly coded, 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.

[98] https://www.england.nhs.uk/ourwork/accessibleinfo/

v. As at present, generic invitations such as messages added to the right-hand side of prescriptions or notices in the waiting room inviting groups of patients to attend clinics or make appointments will not be acceptable.

Invitations for cervical screening

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

ii. Therefore:

a) In those areas where the first two invitations are sent via the central screening service, then contractors are responsible for offering the third invitation.

b) Where the central screening service sends out only one letter, then contractors are responsible for offering the second and third invitation.

c) Where contractors have opted to run their own call/recall system then they are responsible for making all three invitations.

d) Where a woman does not respond to these three invitations then contractors will need to code that this has been the case. Each invitation should be recorded in the patient record as evidence of these may be required for assessment and audit purposes.

e) Women may choose to withdraw from the national screening programme. This should be undertaken with caution as women who withdraw from cervical screening call/recall will receive no further offers of screening from the central service. Where women actively decline cervical screening, this should be recorded as such.

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

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

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

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

6. 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

CG	Clinical guideline (NICE)
CHD	Coronary Heart Disease
$CHADS_2$	Congestive (HF) Hypertension Age (75 or over) Diabetes Stroke
CHA_2DS_2-VASc	Congestive (HF) Hypertension Age (75 or over) Diabetes Stroke (prior stroke) Vascular Disease (peripheral artery disease) Age (65–74 years) Sex Category (i.e. female)
CKD	Chronic Kidney Disease
CMO	Chief Medical Officer
COPD	Chronic Obstructive Pulmonary Disease
CPA	Care Programme Approach
CQRS	Calculating Quality Reporting Service
CRP	C-Reactive Protein
CS	Cervical Screening
CVD	Cardiovascular Disease
CVD-PP	CVD Primary Prevention
DEM	Dementia
DEP	Depression
DM	Diabetes Mellitus
DMARD	Disease Modifying Anti-Rheumatic Drugs
DXA	Dual-Energy X-ray Absorptiometry
ED	Erectile Dysfunction
eGFR	Estimated Glomerular Filtration Rate
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
HF	Heart Failure
HYP	Hypertension
IFCC	International Federation of Clinical Chemistry and Laboratory Medicine
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
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
PCA	Personalised Care Adjustment
PCRJ	Primary Care Respiratory Journal
PEF	Peak Expiratory Flow
PH	Public health
PPI	Proton pump inhibitor
PVD	Peripheral Vascular Disease
QOF	Quality and Outcomes Framework
QS	Quality standard (NICE)
RA	Rheumatoid Arthritis
RCGP	Royal College of General Practitioners
RCP	Royal College of Physicians
RCN	Royal College of Nurses
SFE	Statement of Financial Entitlements
SMOK	Smoking
SPICT	Supportive and Palliative Care Indicators Tool
STIA	Stroke or Transient Ischemic Attack
TA	Technology appraisal (NICE)
TIA	Transient Ischemic Attack
TSH	Thyroid Stimulating Hormone
UK	United Kingdom
US	United States
WHO	World Health Organisation

7. Queries

Queries fall into three main categories:

i. Those which can be resolved by referring to guidance and/or FAQs

ii. Those requiring interpretation of the guidance or business rules

iii. Those not anticipated in guidance

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