NHS England

Quality and Outcomes Framework guidance for 2026/27



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1. Introduction

1.1 Purpose of this document

i. This document provides additional guidance on the interpretation and verification of the Quality and Outcomes Framework (QOF) indicators for 2026/27 in England, which are listed in Annex D of the Statement of Financial Entitlements Directions (SFE). It is effective from 1 April 2026 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

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

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

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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 indicator for coronary heart disease is identified as CHD005. 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 appropriately 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 National Institute for Health and Care Excellence (NICE) led process they will also be annotated with their NICE menu ID number 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 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

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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 General Practitioner (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 QOF business rules. These are based entirely on Systematized Nomenclature of Medicine (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.

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.

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- 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.
- Where an indicator refers to activity 'in the preceding 12 months', the activity must have taken place within the 12 month period ending on 31st March of the relevant QOF year. Retrospective recording is acceptable only where the underlying activity occurred within the defined timeframe
- 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.

iii. In the event where achievement cannot be automatically collected, this should be self-declared through the CQRS website. Contractors will receive notification and associated instruction if this process needs to be implemented. Commissioners may request evidence underpinning this self-declaration as part of their verification processes.

Improvement payments for VI001, VI002 and VI003

i. For the first time in QOF, an additional route to achieving QOF points will be introduced for the three childhood immunisation indicators, VI001, VI002 and VI003. This additional opportunity will be based on making a significant improvement compared with the practice’s baseline and will sit alongside the absolute achievement thresholds that are a standard feature of QOF. The changes will apply from 1 April 2026 and CQRS will be updated later in 2026 to reflect this change. The SFE will be updated later in the year to include the improvement thresholds and approach to achievement calculation. Further details of the rationale and implementation are available in 4.3 Vaccinations and immunisations (VI).

ii. Two separate achievement calculations will be carried out for each of the three indicators. Practices will be awarded points for the calculation which yields the higher points value:

1. **Standard QOF calculation:** Practice achievement is within lower (LT) and upper (UT) thresholds; or

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2. **Improvement calculation:** Practice improvement achievement as compared to the practice's two-year baseline. The improvement achievement requires a minimum increase of 5 percentage points (%pts) from the baseline in order to start qualifying for QOF points. These will be awarded on a sliding scale dependent on the level of improvement. Practices achieving an improvement below 5%pts will not earn QOF points for this calculation method.

iii. The practice baseline will be determined through the average annual achievement for each indicator between 2024-2026. The most recent two year period represents a stable and representative baseline. The baseline for each practice will be available in CQRS.

iv. Achievement will be assessed against the following thresholds:

Indicators	**Points**	**Standard QOF calculation**		**Improvement calculation**		
		LT	UT	Baseline	LT	UT
VI001	18	89%	96%	0%	5%pts	18%pts
VI002	18	86%	96%	0%	5%pts	23%pts
VI003	18	81%	96%	0%	5%pts	30%pts

v. To preserve the integrity of the standard QOF thresholds and its aim to achieve herd immunity, the improvement threshold range is wider than the existing QOF thresholds. This means that practices who consistently achieve within the standard QOF thresholds continue to be incentivised to do so.

vi. For the avoidance of doubt, percentage refers to an absolute number as a proportion of a total. A percentage point is the unit of difference between two percentages. For the improvement achievement calculation, it means the difference between the baseline and the achievement figure. For example, a practice with a baseline of 71% with an achievement figure of 82% has seen an improvement of 11%pts.

vii. The calculations will be carried out as part of the QOF achievement calculations on the last day of the financial year and subject to the details outlined in the SFE. Payments will be subject to practice list adjustments using the practice's contractor population index (CPI).

viii. QOF payments for VI001-VI003 will be made in accordance with the terms set out in the SFE with aspiration payments throughout 2026/27 based on 2025/26 achievement

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and a reconciliation payment in 2027/28. The reconciliation payment will account for earned achievement for these indicators, reflecting the higher point value of the two calculations.

ix. Some practices will not have a historical baseline on which to calculate improvement thresholds, for example practices that have been newly formed since April 2025. In these circumstances, improvement thresholds will not apply.

x. These practices will remain eligible to earn the full range of QOF points available for achievement against the relevant indicators. This approach ensures fairness and avoids the application of arbitrary baselines, while allowing for commissioner discretion where appropriate.

Improvement calculation scenarios

i. The following scenarios aim to illustrate the outcome of dual calculation process, using VI002 as the example. Both calculations use the following QOF formula to calculate the number of points earned (replicated across all QOF calculation):

(Achievement – Lower Threshold) / (Upper Threshold – Lower Threshold) * Number of indicator points = Points earned

	Pts	Standard calculation		Improvement calculation			26/27 achieve-ment	Standard pts earned	Improve-ment pts earned
		LT	UT	LT	UT	Baseline			
A	18	86%	96%	5%	23%	50%	60%	0.00	**5.00**
B	18	86%	96%	5%	23%	82%	89%	**5.40**	2.00
C	18	86%	96%	5%	23%	90%	96%	**18.00**	1.00

- **Practice A: Opportunity to earn points through improvement.** Practice is able to increase their achievement by 10%pts relative to their baseline. They would receive 5 QOF points for this level of improvement ((10%pts-5%pts) / (23%pts-5%pts) * 18 = 5pts). Previously their effort would have gone unrewarded in QOF.
- **Practice B: Would earn against both calculations but standard QOF achievement calculation would be greater**. Practice raises their achievement to 89% from a baseline of 82%. As they would start achieving against the standard QOF achievement calculation, this would yield be more QOF points than the 7%pt achievement increase. Standard calculation: (89%-86%) / (96%-86%) * 18 = 5.4pts, Improvement calculation: (7%pts-5%pts) / (23%pts-5pts) * 18 = 2pts.

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- **Practice C: Standard QOF points greater.** Practice C improves from a 90% baseline to 96%. Whilst they would qualify for points using both calculations, the reward for reaching the upper threshold would significantly outstrip the number of QOF points earned through the improvement calculation (6%pts-5%pts) / (23%pts-5%pts) * 18 = 1pt.

Verification

i. The contractor must ensure they can provide any information that the commissioner may reasonably request to demonstrate achievement. 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. Contractors are not required to routinely submit additional supporting evidence unless specifically requested as part of a verification process. Routine QOF reporting is based on clinical coding and automated data extraction via GPES and CQRS.

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.

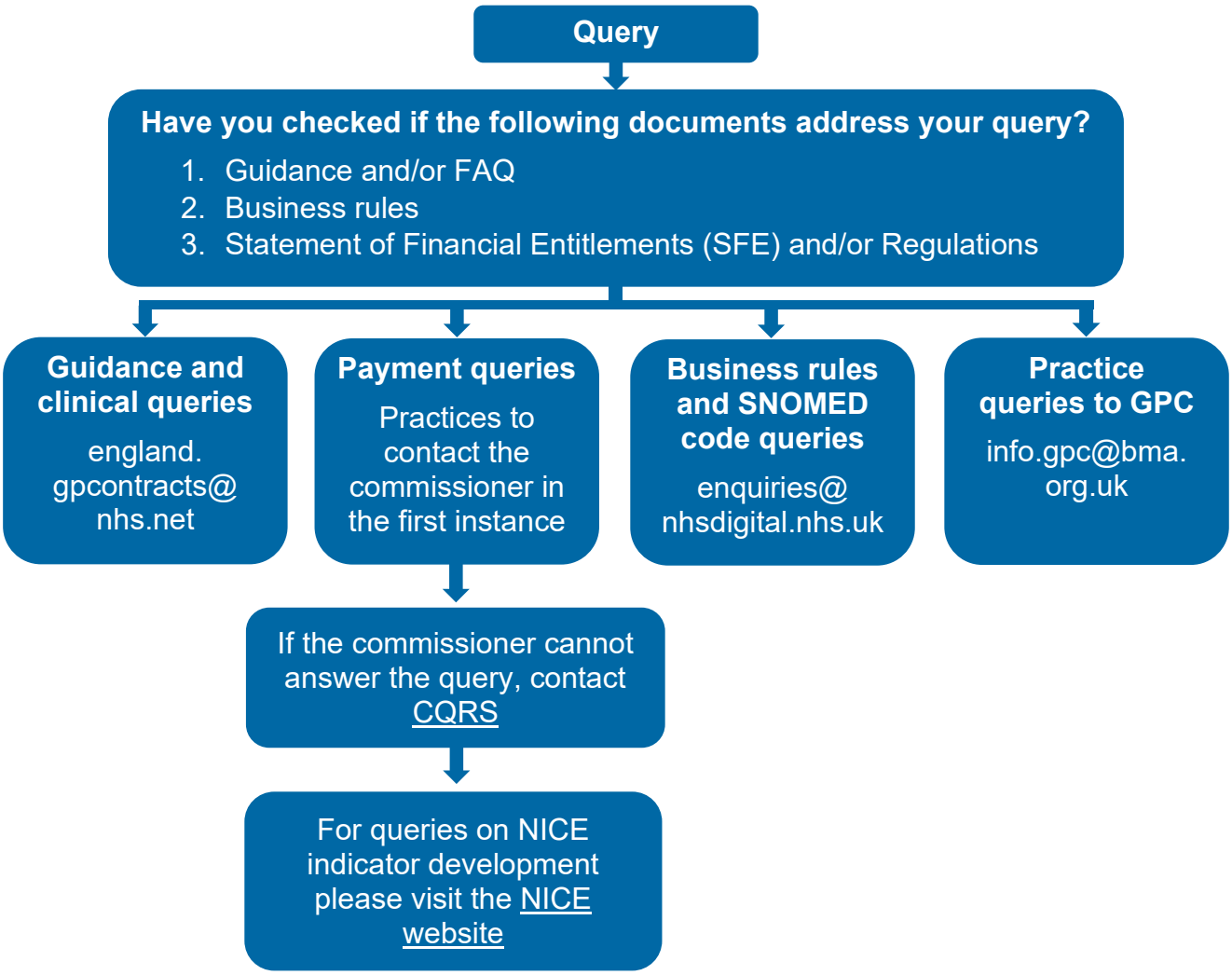
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1.6 Queries

i. Queries fall into three main categories:

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

ii. 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 flowchart below outlines where questions should be directed to, depending on the subject of the query.



2. Summary of all indicators

2.1 Table of indicator changes

Indicator ID	Indicator change	Threshold Changes	Points Changes
AF006	Upper achievement threshold increased	Upper threshold increased from 90 to 95%	Unchanged – 12 pts
AST014	Changed indicator ID due to asthma register change	Unchanged – 45–80%	Unchanged – 15 pts
AST015	Changed indicator ID due to asthma register change	Unchanged – 45–70%	Unchanged – 20 pts
CD001	New blood pressure (BP) control indicator for patients aged ≤79, without frailty, combining and replacing the separate coronary heart disease (CHD) and stroke/TIA (STIA) BP control indicators	New indicator – 40–90%	Reallocated – 41 pts
CD002	New BP control indicator for patients aged 80 or over, without frailty, combining and replacing the separate CHD and STIA BP control indicators	New indicator – 46–90%	Reallocated – 20 pts
CHOL003	Points decreased for consistency with lipid lowering indicators	Unchanged – 70-95%	Reduced from 38 to 20 pts
DM034	Points increased for primary prevention statin use in diabetes	Unchanged – 50–90%	Increased from 4 to 8 pts
DM035	Points increased for secondary prevention statin use in diabetes	Unchanged – 50–90%	Increased from 2 to 8 pts
DM037	New annual diabetes care processes indicator	New indicator – 35-75%	Reallocated – 10 pts

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HF009	New indicator for four-pillar therapy in heart failure with reduced ejection fraction (HFrEF)	New indicator – 20–50%	Reallocated – 12 pts
HYP010	Adjustment to indicator to remove moderately or severely frail patients from the cohort	Unchanged – 40-85%	Unchanged – 38 pts
HYP011	Adjustment to indicator to remove moderately or severely frail patients from the cohort	Unchanged – 40-85%	Unchanged – 14 pts
NDH003 (previously NDH002)	Gestational diabetes patient cohort added and points increased	Unchanged – 50–90%	Increased from 18 to 20 pts
OB004	New referral to weight management programmes indicator for adults living with obesity	New indicator – 10–30%	New – 5 pts
OB005	New shared decision-making and pharmacotherapy indicator for obesity	New indicator – 50–80%	New – 13 pts
STIA007	Ticagrelor included in the list of antiplatelet medications that counts towards QOF achievement	Unchanged – 57-97%	Unchanged – 4 pts
VI001	Addition of improvement threshold calculations	Unchanged – 89-96%	Unchanged – 18 pts
VI002	Addition of MMRV and improvement threshold calculations	Unchanged – 86-96%	Unchanged – 18 pts
VI003	Addition of MMRV and improvement threshold calculations	Unchanged – 81-96%	Unchanged – 18 pts
Asthma register: Underlying business rules amended to include patients from the age of 5			

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COPD register: Underlying business rules amended to address potential under and over-recording of COPD on the register, identified by audit
Retired indicator IDs, replaced with new indicators: CHD015, CHD016, DM012, HF003, HF006, HYP008, HYP009, NDH002, STIA014, STIA015

2.2 Clinical domain (437 points)

Atrial fibrillation (AF)	Points	Thresholds
Ongoing management		
AF006. The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA2DS2-VASc score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more).	12	40-95%
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%
Cardiovascular disease (CD)	**Points**	**Thresholds**
Ongoing management		
CD001. The percentage of patients with coronary heart disease, stroke or TIA, aged 79 years or 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).	41	40-90%

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CD002. The percentage of patients with coronary heart disease, stroke or TIA, aged 80 years or over, without moderate or severe frailty 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).	20	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.	20	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%
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	6	50–90%

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echocardiogram or a specialist assessment within 6 months of the date of registration.		
Ongoing management		
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%
HF009. The percentage of patients with a current diagnosis of heart failure with reduced ejection fraction, who are currently treated with: • an angiotensin-converting enzyme inhibitor or angiotensin receptor-neprilysin inhibitor or angiotensin II receptor blocker; and • a beta blocker; and • a mineralocorticoid receptor antagonist; and • a sodium glucose co-transporter-2 inhibitor.	12	20-50%
Hypertension (HYP)	**Points**	**Thresholds**
Ongoing management		
HYP010. The percentage of patients with hypertension aged 79 years or 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).	38	40-85%
HYP011. The percentage of patients with hypertension aged 80 years or over, without moderate or severe frailty, 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		

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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%
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%
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	8	50-90%

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<10% recorded in the preceding 3 years) or where a statin is declined or if clinically unsuitable, another lipid-lowering therapy.		
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.	8	50-90%
DM037. The percentage of patients with diabetes who have had the following care processes performed in the preceding 12 months: BMI measurement, BP measurement, HbA1c measurement, cholesterol measurement, record of smoking status, foot examination, albumin:creatinine ratio, and eGFR creatinine measurement.	10	35-75%
Asthma (AST)	**Points**	**Thresholds**
Initial diagnosis		
AST014. 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		
AST015. 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%
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	9	50–90%

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breathlessness using the Medical Research Council dyspnoea scale.		
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	7	50-90%

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kg/m2 or >=25 kg/m2 if 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%
Non-diabetic hyperglycaemia (NDH)	**Points**	**Thresholds**
Ongoing management		
NDH003. The percentage of patients with non-diabetic hyperglycaemia or a previous diagnosis of gestational diabetes who have had an HbA1c or fasting blood glucose performed in the preceding 12 months.	20	50–90%

2.3 Public health domain (145 points)

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		

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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 or MMRV 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 or MMRV 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%
Obesity (OB)	**Points**	**Thresholds**
OB004. The percentage of patients aged 18 or over living with obesity, appropriately adjusted for ethnicity in line with NICE guidelines (either with a BMI greater than or equal to 30 kg/m2 recorded in the preceding 12 months, or a BMI greater than or equal to 27.5 kg/m2 recorded in the preceding 12 months for patients with a South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean family background) who have been referred to a weight management programme within 90 days of the BMI being recorded.	5	10-30%
OB005. Percentage of eligible patients (per NICE TA1026 Funding Variation cohorts, accounting for ethnicity and comorbidity status)	13	50-80%

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who have a recorded shared decision-making discussion about the management of obesity and are offered NICE approved medicines management (pharmacotherapy) for use in a primary care setting with accompanying referral to suitable behavioural support programme, in the preceding 12 months.		
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 $CHADS_2$ or CHA_2DS_2-VASc score of 2 or more).	12	40-95%
AF008. Percentage of patients on the QOF Atrial Fibrillation register and with a CHA_2DS_2-VASc score of 2 or more, who were prescribed a direct-acting oral anticoagulant (DOAC), or, where a DOAC was declined or clinically unsuitable, a Vitamin K antagonist.	12	70-95%

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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 20-30% 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 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 Congestive Heart Failure, Hypertension, Age (75 or over), Diabetes, Stroke, Vascular disease, Age (65-74), Sex (CHA_2DS_2-VASc) risk assessment tool.

ii. The CHA_2DS_2-VASc system scores one point, up to a maximum of nine, for each of the following risk factors (except previous stroke or transient ischemic attack (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)
- 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-VASc at any time, or Congestive

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Heart Failure, Hypertension, Age (75 or over), Diabetes, Stroke ($CHADS_2$) prior to 1 April 2015.

AF008 (based on NICE IND247)

AF008 Rationale

i. The newly published 10 year health plan commits to creating a modern service framework for cardiovascular disease aimed at reducing premature deaths from heart disease and stroke by 25% over the next decade.

ii. This indicator aims to support people with AF who are at increased risk of stroke so that they may be offered anticoagulation drug therapy. 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. This indicator was developed to support the NHS Long Term Plan ambitions to reduce the number of people having a stroke and will support the ambition to reduce premature mortality from heart disease and stroke. 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

iv. 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.

v. NICE guidance for diagnosing and managing atrial fibrillation (NG196) recommends 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). 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.

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- predictable effects on clotting, so routine monitoring of clotting factors is not needed.
- wide therapeutic window.

vi. 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%

CHD – rationale for inclusion of indicator set

i. CHD is the single most common cause of premature death in the UK. 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.

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CHD005 (based on NICE IND132)

CHD005 Rationale

i. NICE guidance for acute coronary syndromes recommends all people who have had a myocardial infarction 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.

3.3 Cardiovascular disease (CD)

Indicator	Points	Thresholds
Ongoing management		
CD001. The percentage of patients with coronary heart disease, stroke or TIA, aged 79 years or 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).	41	40-90%
CD002. The percentage of patients with coronary heart disease, stroke or TIA, aged 80 years or over, without moderate or severe frailty 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).	20	46-90%

CD – Rationale for inclusion of indicator set

i. There is clear evidence that appropriate diagnosis and management of CHD and stroke can reduce the risk of death and improve outcomes for patients. This indicator set focuses on managing patients with established CHD or stroke.

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CD001 (based on NICE IND241 and IND243)

CD001 Rationale

i. This indicator measures the intermediate outcome of a blood pressure of 140/90 millimetres of mercury (mmHg) or less in people aged 79 years or under with CHD or a history of stroke or TIA. 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 aligns with 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.

iii. For 2026/27, the separate blood pressure monitoring indicators for CHD and stroke have been combined into a single CD indicator. The indicator implements the recommendation in the NICE guideline for hypertension (NG136) to use clinical judgement for blood pressure targets for patients with frailty. Excluding patients with moderate to severe frailty ensures that practices can offer an approach to care that takes account of multimorbidity and manages hypertension on an individual basis.

CD001 Reporting and verification

i. See indicator wording for requirement criteria.

CD002 (based on NICE IND242 and IND244)

CD002 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 or a history of stroke or TIA, as recommended by the NICE clinical guideline for hypertension. The aim of treating people to this target is to promote secondary prevention of cardiovascular events through satisfactory blood pressure control.

ii. This indicator aligns with 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.

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iii. For 2026/27, the separate blood pressure monitoring indicators for CHD and stroke have been combined into a single CD indicator. The indicator implements the recommendation in the NICE guideline for hypertension (NG136) to use clinical judgement for blood pressure targets for patients with frailty. Excluding patients with moderate to severe frailty ensures that practices can offer an approach to care that takes account of multimorbidity and manages hypertension on an individual basis.

CD002 Reporting and verification

i. See indicator wording for requirement criteria.

3.4 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.	20	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 cardiovascular disease (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.

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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 or stroke/TIA, and those with chronic kidney disease, receive treatment to reduce cholesterol in line with NICE guidelines. This is also reflected in the national guidance for lipid management.

ii. Treatment with a high intensity statin is recommended as first line therapy for the secondary prevention of CVD. When a high intensity statin is declined or clinically unsuitable due to contraindications or intolerance, NICE recommend ezetimibe. If the lipid target for secondary prevention is not met on ezetimibe monotherapy, consider additional lipid-lowering treatments including bempedoic acid, or injectable therapies: alirocumab (TA393, June 2016), evolocumab (TA394, June 2016) or inclisiran (TA733, October 2021) in line with eligibility criteria.

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.

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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.

iii. Where there is an insufficient reduction in cholesterol, treatment should be intensified in line with NICE guidance.

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 (monoclonal antibodies), an LDL cholesterol > 3.5 or 4mmol/L depending on their risk profile. Where statin intolerance exists and ezetimibe monotherapy is ineffective, the addition of bempedoic acid may be considered in line with the statin intolerance pathway.

CHOL004 Reporting and verification

i. See indicator wording for requirement criteria.

3.5 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 of an echocardiogram or a specialist assessment within 6 months of the date of registration.	6	50–90%
Ongoing management		

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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%
HF009. The percentage of patients with a current diagnosis of heart failure with reduced ejection fraction, who are currently treated with: • an angiotensin-converting enzyme inhibitor or angiotensin receptor-neprilysin inhibitor or angiotensin II receptor blocker; and • a beta blocker; and • a mineralocorticoid receptor antagonist; and • a sodium glucose co-transporter-2 inhibitor.	12	20-50%

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.

ii. Analysis of primary care records have highlighted some inconsistent recording of heart failure ejection fraction category (reduced, mildly reduced or preserved). It is important that patient records reflect this category in order to avoid unwarranted variations in treatment, under and overtreatment, both of which could lead to poor patient outcomes. Practices should ensure that the ejection fraction category, where applicable, is recorded for all patients.

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

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identify causes. The NICE guideline for chronic heart failure recommends that the results of N-terminal pro B-type natriuretic peptide (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 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.

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.

HF009 (based on NICE IND317)

HF009 Rationale

i. The aim of this indicator is to ensure patients with heart failure with reduced ejection fraction (HFrEF) receive optimal care. The NICE guideline for chronic heart failure (NG106) was updated in September 2025 to recommend HFrEF patients are offered four key disease-modifying drugs, sodium-glucose cotransporter-2 (SGLT2) inhibitor alongside beta-blocker, mineralocorticoid receptor antagonist (MRA) and one of angiotensin-converting enzyme inhibitor (ACE-I), angiotensin II receptor blocker

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(ARB) or angiotensin receptor-neprilysin inhibitor (ARNI). These drugs have been described as the four pillars of care for heart failure patients.

ii. NICE states that the four pillar medication approach is cost-effective and leads to a reduction in cardiovascular-related mortality and hospital admissions.

iii. This indicator replaces two existing QOF indicators, HF003 and HF006.

HF009 Reporting and verification

i. See indicator wording for requirement criteria.

3.6 Hypertension (HYP)

Indicator	Points	Thresholds
Ongoing management		
HYP010. The percentage of patients with hypertension aged 79 years or 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).	38	40-85%
HYP011. The percentage of patients with hypertension aged 80 years or over, without moderate or severe frailty, 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%

HYP010 (based on NICE IND239)

HYP010 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, without moderate or severe frailty. 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 aligns with 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.

iii. The updated indicator, previously HYP008, implements the recommendation in the NICE guideline for hypertension (NG136) to use clinical judgement for blood pressure targets for patients with frailty. Excluding patients with moderate to severe frailty ensures that practices can offer an approach to care that takes account of multimorbidity and manages hypertension on an individual basis.

HYP010 Reporting and verification

i. See indicator wording for requirement criteria.

HYP011 (based on NICE IND240)

HYP011 Rationale

i. The NICE guideline for hypertension (NG136) 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 aligns with 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.

iv. This indicator, previously HYP009, implements the recommendation in the NICE guideline for hypertension (NG136) to use clinical judgement for blood pressure targets for patients with frailty. Excluding patients with moderate to severe frailty ensures that practices can offer individualised management of hypertension which accounts for multimorbidity.

HYP011 Reporting and verification

i. See indicator wording for requirement criteria.

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3.7 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%

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 NICE evidence that appropriate diagnosis and management can improve outcomes.

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

ii. The British National Formulary (BNF) makes the following stroke treatment 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.

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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.

STIA007 Reporting and verification

i. See indicator wording for requirement criteria.

3.8 Diabetes mellitus (DM)

Indicator	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%
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%

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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.	8	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.	8	50-90%
DM037. The percentage of patients with diabetes who have had the following care processes performed in the preceding 12 months: BMI measurement, BP measurement, HbA1c measurement, cholesterol measurement, record of smoking status, foot examination, albumin:creatinine ratio, and eGFR creatinine measurement.	10	35-75%

DM – rationale for inclusion of indicator set

i. Diabetes mellitus (DM) is a common endocrine disease. In March 2025, there were approximately 4 million people living with diagnosed diabetes in England. Effective management and monitoring can reduce mortality and morbidity. Much of this, particularly for people with type 2 diabetes, is undertaken by the GP and members of the primary care team.

ii. 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.

iii. Further information:

- NICE NG28 (2015, updated 2026) Type 2 diabetes in adults.
- NICE NG19 (2015, updated 2019) Diabetic foot problems.
- NICE NG18 (2015, updated 2023) Diabetes (type 1 and type 2) in children and young people.
- NICE NG17 (2015, updated 2022) Type 1 diabetes in adults.

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DM006 (based on NICE IND134)

DM006 Rationale

i. NICE guidelines for type 1 diabetes and type 2 diabetes in adults 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 to people with type 2 diabetes and are effective in slowing progression of 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.

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 diabetes in taking control of their condition and in delivering effective self-management. Structured education programmes are supported by NICE guidance for type 1 diabetes and type 2 diabetes in adults.

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.

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iii. This indicator suggests referral to a programme within nine months of entry onto the diabetes register to be appropriate for people with 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 diabetes 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.

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. 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 aligns with 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 140/90 mmHg for clinic blood pressure corresponds to an HBPM target of 135/85 mmHg.

DM036 Reporting and verification

i. See indicator wording for requirement criteria.

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DM020 (based on NICE IND179)

DM020 Rationale

i. Glycated haemoglobin (HbA1c) is commonly used to monitor glucose control as it provides a measure of glycaemia over the preceding 8-12 weeks. Rising levels of HbA1c increase the risk of mortality and developing macrovascular and microvascular complications. However, applying universal target levels regardless of comorbidities may inadvertently lead to over-treatment, especially in older people with type 2 diabetes and people living with frailty. 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 for type 1 diabetes and type 2 diabetes in adults, this has been pragmatically selected as a point at which treatment intensification should be considered in people with type 2 diabetes.

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 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.

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DM034 (based on NICE IND275)

DM034 Rationale

i. Cardiovascular risk is elevated in people with diabetes. The NICE guideline for cardiovascular disease risk assessment and lipid modification 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. The NICE guideline for cardiovascular disease: risk assessment and reduction, including lipid modification reinforces the recommendation of high-intensity statin treatment, for primary prevention (atorvastatin 20mg) and secondary prevention (atorvastatin 80mg). This indicator reflects the potential for use of other lipid lowering therapies where a statin is declined, not tolerated or otherwise clinically unsuitable.

DM034 Reporting and verification

i. See indicator wording for requirement criteria.

ii. People with type 2 diabetes who have a 10-year risk of developing CVD of less than 10% 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 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 LDL cholesterol and is associated with a reduction in MI, coronary heart disease and stroke. Treatment should start with atorvastatin 80mg, however there are situations in which a lower dose or alternative lipid lowering therapy should be used. This indicator reflects the potential for use of other lipid lowering therapies where a statin is declined, not tolerated or otherwise clinically unsuitable.

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DM035 Reporting and verification

i. See indicator wording for requirement criteria.

DM037 (based on NICE IND120)

DM037 Rationale

i. NICE guidelines on type 1 diabetes and type 2 diabetes recommend that people aged 12 years or over with diabetes should receive a bundle of 8 key care processes annually (with retinal screening also recommended but typically organised through diabetes retinal screening providers).

ii. The aim of the care processes is to monitor key risk factors for complications of diabetes and support early identification and monitoring of complications if they develop, informing treatment plans and action accordingly. Evidence shows that completion of all 8 care processes is associated with reduced mortality in people with diabetes.

DM037 Reporting and verification

i. See indicator wording for requirement criteria.

3.9 Asthma (AST)

Indicator	Points	Thresholds
Initial diagnosis		
AST014. 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		
AST015. 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%

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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.

AST014 (based on NICE IND272)

AST014 Rationale

i. This indicator reflects the recommendations made in the 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:

ii. 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

iii. If asthma is not confirmed by eosinophil count or FeNO level, measure bronchodilator reversibility (BDR) with spirometry. Diagnose asthma if the Forced Expiratory Volume in One Second (FEV1) increase is 12% or more and 200 ml or more from the pre-bronchodilator measurement (or if the FEV1 increase is 10% or more of the predicted normal FEV1)

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iv. 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.

v. 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. Diagnose asthma if bronchial hyper-responsiveness 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 FEV1 increase is 12% or more from baseline (or if the FEV1 increase is 10% or more of the predicted normal FEV1).

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 Immunoglobulin E (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 109 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 obtained. Personalised Care Adjustment (PCAs) are available for situations where the patient declines or does not attend, or if objective tests are not appropriate or feasible.

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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.

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.

AST014 Reporting and verification

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

AST015 (based on NICE IND273)

AST015 Rationale

i. This indicator reflects the recommendations made in the combined asthma guideline produced by NICE, BTS and SIGN.

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-

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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 beta2 agonists should not be prescribed to people of any age with asthma without a concomitant prescription of an inhaled corticosteroid (ICS) (1.6.3) and algorithms have been produced for the pharmacological management of asthma in people aged 12 years and over and the pharmacological treatment of children aged 5 to 11 years.

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 not controlled on paediatric moderate-dose Maintenance and Reliever Therapy (MART) or paediatric moderate-dose ICS/Long-acting beta-2 agonist (LABA) maintenance treatment (with or without an Leukotriene receptor antagonist (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), further information to support the implementation of both AST015 and AST014 can be found from:

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- Asthma + Lung UK
- British Thoracic Society
- Primary Care Respiratory Society
- beatasthma.co.uk (for children and young people)

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

AST015 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.

3.10 Chronic obstructive pulmonary disease (COPD)

Indicator	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%

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.

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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.

iii. For 2026/27, the COPD register has been revised with the aim of improving the accuracy, removing patients incorrectly added to the register and adding patients receiving COPD care but who are not coded as having COPD and were previously not included. This work has been overseen by the national clinical director for respiratory disease and has involved removing and adding codes, including a number of COPD process codes.

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 personalised 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 is 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.

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COPD0010 Reporting and verification

i. See indicator wording for requirement criteria.

3.11 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 contributes to around 50 to 75 per cent of cases of dementia with vascular dementia accounting for up to 20 per cent.

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 rarer but can be distressing or disabling.

DEM004 (based on NICE IND142)

DEM004 Rationale

i. The NICE guideline for dementia recommends that people with dementia have a care plan developed in collaboration with health and social services with 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 with the patient and their carers.

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iii. Where the initial diagnosis and care plan has been provided in a secondary care setting, the GP patient record should be updated at the earliest opportunity to reflect that diagnosis. Where a patient appears within the denominator for this indicator but it is not appropriate to review the care plan as it has been too recently initiated, then a personalised care adjustment can be applied as the practice deems appropriate.

iv. 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 and the aims of the 10 Year Health Plan for England, 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
  - any ongoing antipsychotic medication, considering current or future side effects including cardiovascular disease, diabetes and falls risk
  - other prescribed medications, particularly those with anticholinergic effects.
- 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, including referrals to relevant services to support their health and wellbeing. 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.

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. The practice should agree with the patient on the most appropriate appointment length and whether it would be better to divide the consultation into two separate appointments. Ideally, the first appointment should be within six months.

vi. Studies show that people with dementia may not report common physical symptoms like joint pain or infections. Patient assessments should consider:

- frailty score
- mobility decline and falls and fracture risks
- hearing and visual impairments
- physical conditions (e.g. joint pain or inter-current infections) that might present with behavioural changes
- psychiatric symptoms related to dementia such delusions, hallucinations, depression, anxiety or restlessness.

vii. Patients and carers should 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 supporting information. As the illness progresses, needs may change, and the review may focus more on issues such as respite care or longer-term care needs.

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.

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x. Further information:
- NICE NG97 (2018) Dementia
- NICE QS184 (2019) Dementia
- Forget me not dementia training
- Department of Health and Social Care (2001) National Service Framework for Older People
- NICE PH16 (2008) Mental wellbeing in over 65s: occupational therapy and physical activity interventions
- NHS (2025) Looking after someone with dementia

DEM004 Reporting and verification

i. See indicator wording for requirement criteria.

ii. Verification – Commissioners may require randomly selecting a number of records of patients in which the review has been recorded as taking place to confirm that key issues have been addressed.

3.12 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%

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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%

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. 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.

iv. NICE guideline for managing psychosis and schizophrenia in adults (CG178) recommends that primary care utilise registers to monitor the physical health of patients with psychosis or schizophrenia. The health check should be comprehensive,

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focusing on physical health problems that are common in people with psychosis and schizophrenia. NICE recommends health checks should include the following:

- weight (plotted on a chart)
- waist circumference
- pulse and blood pressure
- 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 guideline for bipolar disorder (CG185) recommends that patients with bipolar affective disorder have a physical health review, normally in primary care, performed at least annually, including:

- weight or body mass index (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. 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). Risk is further compounded by substantially higher rates of smoking than in the general population. A full annual check and supported signposting to appropriate interventions is therefore important for reducing risk.

vii. Further information

- NICE CG178 (2014) Psychosis and schizophrenia in adults.
- Practices may wish to utilise the Lester tool; a mental health physical review template

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MH002 (based on NICE IND143)

MH002 Rationale

i. This indicator reflects good professional practice and is supported by NICE guidelines for managing psychosis and schizophrenia in adults (CG178) and bipolar disorder (CG185).

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.

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

MH002 Reporting and verification

i. See indicator wording for requirement criteria.

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

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 for managing psychosis and schizophrenia in adults (CG178) and bipolar disorder (CG185) 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

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cardiovascular mortality of people with schizophrenia has increased over the past 25 years relative to the general population. The NICE guideline on bipolar disorder also states that the standardised mortality ratio for cardiovascular death may be twice that of the general population but appears to be reduced if patients adhere to long-term medication.

ii. 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.

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

iv. MH007 incentivises delivering the requirement to record alcohol intake as part of the physical check. Alcohol and other substance misuse by people with schizophrenia is increasingly recognised as a major problem, both in terms of its prevalence and its clinical and social effects. The National Psychiatric Morbidity Survey in England found that 16% of people with schizophrenia were drinking above the lower risk consumption levels (14 units) of alcohol. Bipolar affective disorder is also highly co-morbid with alcohol and other substance abuse.

v. NICE guidance for managing psychosis and schizophrenia in adults (CG178) and bipolar disorder (CG185) 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 and antipsychotic medication can be diabetogenic. 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.

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

3.13 Non-diabetic hyperglycaemia (NDH)

Indicator	Points	Thresholds
Records		
NDH003. The percentage of patients with non-diabetic hyperglycaemia or a previous diagnosis of gestational diabetes who have had an HbA1c or fasting blood glucose performed in the preceding 12 months.	20	50–90%

NDH – rationale for inclusion of indicator set

i. NDH (nondiabetic hyperglycaemia; 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. There were more than 4.2 million people with NDH in England in March 2025, representing an increase of approximately half a million people year on year.

ii. Approximately 420,000 women had a history of Gestational Diabetes Mellitus (GDM) coded in their General Practice record in March 2025, with an additional 240,000 recorded as having had GDM in hospital records.

iii. NDH and GDM are major risk factors for type 2 diabetes. NICE guidance (PH38 and NG3 respectively, and QS109) therefore recommends that people with NDH or a history of GDM should be offered annual glycaemic testing to check for development of type 2 diabetes.

iv. The NHS has invested significantly in behavioural interventions for those with NDH or a history of GDM 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 1 million 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.

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v. The NHS DPP is available across the whole of England, and GP practices can refer patients aged 18 years or over with a blood test result demonstrating NDH in the 12 months prior to referral or with a history of GDM at any point previously (women with a history of GDM can also self-refer). 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.

NDH003 (based on NICE IND172 and IND173)

NDH003 Rationale

i. NICE guidance for preventing type 2 diabetes (PH38) recommends that everyone with NDH is offered an annual blood test to check for progression to Type 2 diabetes.

ii. For 2026/27, the indicator (previously NDH002) has been updated to include women with a history of GDM. Although NICE guidance for diabetes in pregnancy (NG3) recommends annual blood tests for women with previous GDM to check for progression to Type 2 diabetes, data from the National GDM Audit suggests that the rates of annual glycaemic monitoring are only around 50-60%, with considerable potential for improvement.

iii. The aim of this indicator is to improve ongoing monitoring of these high risk groups and promote early identification if people progress to type 2 diabetes. 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.

NDH003 Reporting and verification

i. See indicator wording for requirement criteria.

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

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

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

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

BP002 Reporting and verification

i. See indicator wording for requirement criteria.

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

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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, causes significant health inequality and prevents people from working. In England, more than 1 in 10 people smoke, with smoking prevalence higher in deprived populations, for example, 19.2% of adults in routine and manual occupations smoke as do 24% of people with a long-term mental health conditions and over 40% for people with a severe mental illness. Smoking causes or exacerbates over 100 conditions, including cancers, respiratory disease, cardiovascular disease, depression, psychosis and schizophrenia. Smoking during pregnancy can cause serious pregnancy related health problems including risk of miscarriage, premature birth, still birth, low birth weight and sudden unexpected death in infancy and has a detrimental impact on infancy through to childhood.

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 providing 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,

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such as follow-up appointments with a GP or practice nurse trained in smoking cessation, may be offered.

iv. The NICE guidance on tobacco identifies the evidence-based interventions for adults who smoke:
- behavioural support (individual and group)
- very brief advice
- bupropion
- nicotine replacement therapy (NRT) – short and long acting
- varenicline
- Cytisinicline (cytisine)
- nicotine-containing e-cigarettes (vapes)

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:

1. Smokers

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

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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 (vapes) who have never smoked or given up smoking should be classified as non-smokers or ex-smokers respectively. Patients who dual use electronic cigarettes and cigarettes should continue to be classed and treated as smokers.

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.

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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	Absolute: 89-96% Improvement: 5%pt-18%pt
VI002. The percentage of children who reached 18 months old in the preceding 12 months, who have received at least 1 dose of MMR or MMRV between the ages of 12 and 18 months.	18	Absolute: 86-96% Improvement: 5%pt-23%pt
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 or MMRV between the ages of 1 and 5 years.	18	Absolute: 81-96% Improvement: 5%pt-30%pt
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%

For QOF purposes, either MMR or MMRV counts towards achievement equally.

VI – rationale for inclusion of indicator set

i. Vaccination is one of the most effective public health interventions in the modern era. It ranks second only to clean water as the most effective public health intervention to prevent disease. Childhood vaccines alone prevent between 3.5 and 5 million deaths every year across the globe. 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.

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Note on vaccinations delivered overseas

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

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

iii. Where a patient has been vaccinated overseas in accordance with the UK national schedule, the practice can ensure that the vaccination counts towards QOF achievement but does not attract an item of service payment by coding the vaccination event in the following way:
   1. Backdate the event date of the vaccination procedure SNOMED code and enter the code to accurately reflect when the vaccination was delivered.
   2. Set the GMS flag to ‘No’ (for Optum and INPS practices) or the ‘Event done’ flag to ‘No’ (for TPP practices).
   3. 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)

i. 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).

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ii. 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.

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 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

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

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

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

iv. If a child registered with a practice between 1-4 months of age and had no doses of diphtheria, tetanus and pertussis containing vaccine prior to registering and the practice does not give all three doses before the child turns 8 months old, then the practice would not achieve the indicator for this specific child. The automated PCA would not apply.

For VI002

i. If a child has reached 17 or 18 months of age when registering with the practice and had not had an MMR or MMRV vaccination, then the automatic PCA will be applied. However, if the child is 16 months or younger and does not receive one dose of MMRV 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 vaccinations which could be ether MMR or MMRV but no booster diphtheria, tetanus, acellular pertussis and inactivated poliomyelitis vaccine

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(DTap/IPV) or (2) only one MMR or MMRV vaccination 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 or MMRV vaccination and no booster DTap/IPV or (2) no MMR or MMRV vaccination 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 or MMRV 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 MMRV 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.

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.

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VI002 (based on NICE IND216)

VI002 Rationale

i. MMR is the combined vaccine that protects against measles, mumps and rubella. From 1 January 2026, a combined MMRV vaccine was rolled out as part of the childhood routine 2-dose vaccination schedule. See Green Book for further details. For QOF purposes, either counts towards achievement equally. Measles, mumps and rubella are highly infectious conditions that can have serious complications such as meningitis and encephalitis. Varicella (chickenpox) is an acute, highly infectious disease that can have severe complications.

ii. The first MMRV vaccine (MMRV1) is due as part of the routine vaccination schedule for England within a month of the child's first birthday.

iii. The indicator supports early vaccination. 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.

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.

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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 1 September 2023 the shingles vaccine should be offered to those turning 65 years of age and those aged 70 to 79. 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.

Improvement thresholds for VI001, VI002 and VI003

Rationale

i. Childhood vaccination coverage varies significantly geographically. Data shows a strong correlation between practices' Indices of Multiple Deprivation (IMD) decile and their achievement against the childhood vaccination indicators in QOF. Practices in deprived areas are less likely to reach the lower achievement threshold for these indicators. This aligns with long-standing evidence that deprivation impacts on uptake of vaccinations. A policy report from the Royal College of Paediatrics and Child Health highlighted several complex factors that contribute to this, including access barriers, socioeconomic factors, health literacy, trust in authorities and health beliefs.

ii. This means that QOF may be less effective for incentivising childhood vaccination uptake in some areas. The introduction of an additional way to earn QOF points seeks to address this. The improvement thresholds and calculations will reward the relative effort of practices that have worked hard to increase uptake but are still short of the lower thresholds. They create an additional, realistic and achievable incentive for practices to increase uptake in their registered population.

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iii. The improvement thresholds will help practices to deliver improvements in vaccine uptake in a challenging environment. They will support those practices that can improve their achievement without jeopardising World Health Organisation (WHO) herd immunity targets and not disadvantaging or disincentivising those practices that have been able to reach the current achievement thresholds.

Reporting and verification

i. The maximum number of points available will be unchanged for all three indicators whether a practice earns points through reaching the standard QOF thresholds or through reaching the new improvement thresholds.

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. 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.

4.4 Obesity (OB)

Indicator	Points	Thresholds
OB004. The percentage of patients aged 18 or over living with obesity, appropriately adjusted for ethnicity in line with NICE guidelines (either with a BMI greater than or equal to 30 kg/m2	5	10-30%

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recorded in the preceding 12 months, or a BMI greater than or equal to 27.5 kg/m2 recorded in the preceding 12 months for patients with a South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean family background) who have been referred to a weight management programme within 90 days of the BMI being recorded.		
OB005. Percentage of eligible patients (per NICE TA1026 Funding Variation cohorts, accounting for ethnicity and comorbidity status) who have a recorded shared decision-making discussion about the management of obesity and are offered NICE approved medicines management (pharmacotherapy) for use in a primary care setting with accompanying referral to suitable behavioural support programme, in the preceding 12 months.	13	50-80%

OB – rationale for inclusion of indicator set

i. Data show that around 1 in every 4 adults in England are living with obesity. In the past 30 years, obesity rates have doubled. It is a serious health concern that increases the risk of many other health conditions, including cardiovascular disease, type 2 diabetes, joint problems, mental health problems and some cancers. This is particularly important for Black, Asian, and other minority groups whose risk of conditions is increased at a lower BMI and waist circumference than the general population.

ii. Living with obesity can negatively affect quality of life and contributes to widening health inequalities. Obesity prevalence is higher among people living in areas classified within the most deprived Index of Multiple Deprivation (IMD) deciles, reflecting the strong social gradient associated with the condition. Obesity also has wider societal impacts, including reduced work productivity and an increased risk of hospital admissions.

iii. Addressing obesity is a key commitment in the 10 Year Health Plan for England: Fit for the Future with a range of actions aimed at preventing children and adults to develop obesity and improving the management and treatment of obesity.

iv. The Weight Management Enhanced Service will be withdrawn and cease on 31 March 2026 as a result of inclusion in QOF.

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OB004

OB004 Rationale

i. The indicator aims to ensure consistent identification of adults living with obesity and equitable access to weight management support. It also aims to reduce unwarranted variation across practices and systems by standardising eligibility and referral criteria, with explicit attention to ethnicity-adjusted BMI thresholds. Early referrals for weight management programmes enable timely intervention before patients progress to needing pharmacotherapy, improved outcomes and reduced long term system costs.

ii. The indicator operationalises the NICE guidance on obesity management (NG246), which states that all adults living with obesity should be offered a structured behavioural intervention. Practices should identify adults living with obesity through BMI recording, appropriately coded by ethnicity and comorbidity risk. Patients should be systematically assessed and offered structured weight management support as the foundation of care. This means moving from opportunistic case finding to proactive treatment. The indicator further aligns with the NICE quality standard for the prevention, behavioural management, assessment, and treatment of overweight, obesity and central adiposity in adults (QS212).

iii. The indicator requires that, as part of shared decision-making, clinicians consider the full range of available weight management support, with patients offered the most appropriate option based on individual need, preference, and local availability. To support this, locally relevant services should be mapped and made visible to clinicians and practices, so that local provision can be used alongside national programmes where appropriate. This is inclusive of the NHS Digital Weight Management Programme, and relevant local authority commissioned weight management services and national tailored programmes, such as the NHS Diabetes Prevention Programme (DPP) and NHS Type 2 Path to Remission Programme (T2DR), where weight loss and associated behavioural change are defined and measured outcomes.

OB004 Reporting and verification

i. See indicator wording for requirement criteria.

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OB005

OB005 Rationale

i. The indicator aims to support practices to identify adults living with obesity and promote equitable access to behavioural interventions and treatment options, following shared decision making with the patient. It also aims to reduce unwarranted variation across practices and systems by standardising eligibility, referral, and initiation processes, with explicit attention to ethnicity adjusted BMI thresholds and comorbidity risks.

ii. The indicator aligns the use of weight-management pharmacotherapies with NICE guidance on obesity management (NG246), the Technology Appraisal (TA1026) and the associated NICE Funding Variation for tirzepatide (Mounjaro®) in primary care. It reflects the clear principle within both NICE guidance and the product licence that pharmacotherapy is an adjunct to, and not a substitute for, dietary modification and increased physical activity. By embedding a requirement for structured and timely referral to behavioural wraparound support alongside any pharmacological treatment, the indicator ensures that prescribing takes place within a comprehensive, evidence-based care pathway. This approach supports safe, clinically effective, and cost-effective pharmacotherapy use while promoting equitable access for eligible patients in line with NHS commissioning guidance.

iii. The indicator promotes evidence-based prescribing, underpinned by robust shared decision making, and strengthens population health management through necessitating recording of ethnicity and comorbidity data. It is envisaged that this approach will improve patient outcomes and generate long-term efficiencies by reducing obesity related morbidity and lowering demand on primary and secondary care.

iv. The indicator explicitly recognises weight management pharmacotherapy will not be clinically appropriate for all patients, nor will it be a preferred option for every individual. Decisions to initiate pharmacological treatment in primary care must therefore be guided by clinical appropriateness and robust shared decision-making, taking into account patient preferences, treatment goals, capacity to engage with behavioural support, comorbidities, and potential risks and benefits. This ensures that pharmacotherapy is offered only where it aligns with both NICE guidance, the NICE Funding Variation for tirzepatide (Mounjaro®) in primary care and the informed choice of the patient, and that alternative non-pharmacological interventions are appropriately considered and discussed.

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v. To ensure that patient cohorts with the highest priority are able to access pharmacotherapy in primary care, NHS England has published an interim commissioning guidance for the initial 3 years of implementation, from 2025-2028. Over this period, it is estimated that approximately 220,000 patients will be prescribed NICE approved pharmacotherapies for the management of obesity in primary care.

OB005 Reporting and verification

i. See indicator wording for requirement criteria.

ii. For the full eligibility criteria, see the NHS interim commissioning guidance. In summary, eligible patients need to meet the minimum BMI thresholds, adjusted for ethnicity, and have at least 4 comorbidities from the following qualifying weight-related conditions: hypertension, dyslipidaemia, obstructive sleep apnoea, type 2 diabetes and cardiovascular disease. Eligibility criteria align to the relevant implementation year of the funding variation.

4.5 Cervical screening (CS)

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

CS indicator 005 (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.

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ii. From 1 July 2025, the routine cervical screening interval changed from every 3 years to every 5 years for women and people with a cervix aged 25 to 49 who test negative for high-risk Human Papillomavirus (hrHPV) at their screening appointment. As this was implemented prospectively and the indicators are retrospective, the two separate indicators remain for 2026/27 and changes to QOF are not anticipated to be required until 2028/29. Individuals in this cohort should continue to be invited for their next screening in accordance with their next test due date.

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

iv. During 2025/26 the NHS Cervical Screening Programme delivered a number of transformational change projects that supported practices in their efforts to achieve QOF indicators. This support will continue in 2026/27 with further transformational change projects. Once confirmed, further guidance will be made available on the NHS Cervical Screening professional guidance pages on GOV.UK.

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 5 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. Personalised Care Adjustment (PCA) allows practices to differentiate between the following reasons for adjusting care and removing a patient from the indicator denominator:

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- **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 (via 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. 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.

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

v. Where a patient meets the achievement criteria for an indicator, the indicator will be achieved for that patient and a PCA will apply. Achievement of an indicator takes precedence over the application of a PCA, even where a PCA code has been recorded.

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

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

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.

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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.

1. The investigative service or secondary care service is unavailable

i. This personalised care adjustment will apply only to DM014, OB004 and OB005.

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. 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
OB004	Anytime in the QOF year
OB005	Anytime in the QOF year

2. 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.

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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 PCA may then be applied.

3. 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.

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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.

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

v. 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.

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

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. 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.

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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.

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. 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.

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5. 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.

6. 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.

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