NATIONAL HEALTH SERVICE, ENGLAND

The General Medical Services Statement of Financial Entitlements (Amendment) Directions 2025

The Secretary of State gives the following Directions in exercise of the powers conferred by sections 78, 272(7) and (8) and 273(1) of the National Health Services Act 2006(**a**).

In accordance with section 87(4) of that Act, the Secretary of State has consulted with the body appearing to the Secretary of State to be representative of persons to whose remuneration these Directions relate**.**

Citation, commencement, extent, application and interpretation

1.—(1) These Directions may be cited as the General Medical Services Statement of Financial Entitlements (Amendment) Directions 2025.

(2) These Directions come into force on 1st of April 2025 except as otherwise provided for in paragraphs (3) and (4).

(3) Directions 2(7) comes into force on 1st July 2025.

(4) Directions 2(8) comes into force on 1st September 2025.

(5) These Directions are given to NHS England.

(6) These Directions extend to England and Wales but apply to England only.

(7) In these Directions, "The Principal Directions" means the General Medical Services Statement of Financial Entitlements Directions 2024(**b**).

Amendment of the Principal Directions

2.—(1) The Principal Directions are amended as follows.

(2) In Part 1(global sum)—

(a) in section 3(4), for "£112.50" substitute "£121.79";

(b) in section 3(9)(d), for "£112.50" substitute "£121.79"; and

(c) in section 3(19), for "2024" substitute "2025", for "9,964" substitute "10,184"(**c**).

(a) 2006 c.41. Section 87 is amended by paragraphs 1 (1) and (2) of Schedule 1 to the Health and Care Act 2022 (c.31). By virtue of section 271(1) of the National Health Service Act 2006, the powers conferred by these sections are exercisable by the Secretary of State only in relation to England.

(b) The Directions were signed on 25th March 2024 and were amended by the General Medical Services Statement of Financial Entitlements (Amendment) Directions 2024 signed on 28th August 2024 and the General Medical Services Statement of Financial Entitlements (No.2)(Amendment) Directions 2024 signed on 25th September 2024. Copies of the Directions are available at www.gov.uk/government/publications/nhs-primary-medical-services-directions-2013. Hard copies can be obtained from the Department of Health and Social Care, 4th Floor, 39 Victoria Street, London SW1H 0EU.

(c) The national average practice population figures are taken from the Calculating Quality Reporting Services (CQRS) on 1st January 2025.

(3) For Part 2 (quality and outcomes framework), substitute Part 2 as set out in Schedule 1 to these Directions.

(4) In Part 3 (directed enhanced services)—

(a) in the sub-heading, for "1st April 2024" substitute "1st April 2025" and for "31st March 2025" substitute "31st March 2026";

(b) in section 7(4)(b)(i), for "30th April 2024" substitute "30th April 2025", for "1st April 2024" substitute "1st of April 2025" and for "31st March 2025" substitute "31st March 2026";

(c) in section 7(4)(b)(ii),, for "30th April 2024" substitute "30th April 2025" for "1st April 2024" substitute "1st April 2025" and for "31st March 2025" substitute "31st March 2026";

(d) in section 7(4)(c)(i) for "1st April 2024" substitute "1st April 2025";

(e) in section 7(5)(a), for "31st March 2025" substitute "31st March 2026";

(f) in section 7(5)(b), for "31st March 2025" substitute "31st March 2026";

(g) in section 7(7), for "1st April 2024" substitute "1st April 2025" and for "31st March 2025" substitute "31st March 2026";

(h) in the sub-heading above section 8, for "learning disabilities health check scheme for the period 1st April 2024 to 31st March 2025" substitute "learning disabilities health check scheme for the period 1st April 2025 to 31st March 2026";

(i) in section 8(1), for "1st April 2024" substitute "1st April 2025" and for "31st March 2025" substitute "31st March 2026";

(j) in section 8(3)(b), for "the contractor" substitute "a contractor";

(k) after section 8(3)(b), insert—

"(c) NHS England may accept a claim if an annual health check was carried out for a patient who died during the monthly reporting period or prior to the data extraction date following the end of the monthly reporting period".

(l) in section 8(4)(a), for "the contractor" in both places it occurs, substitute "a contractor".

(5) In Part 4 (payments for specific purposes)—

(a) in section 9(5)(a), for "£1,211.64" substitute "£1,418.43";

(b) in section 9(5)(b), for "£1,856.61" substitute "£2,151.96";

(c) in section 10(5), for "£1,856.61" substitute "£2,151.96";

(d) in section 11(5), for £1,199.64" substitute "£1,404.38";

(e) in section 12(3), for £141.70" substitute "£165.88";

(f) in section 12(7), for £1,199.64" substitute "£1,404.38";

(g) in section 16(16)(a), for "Bridge House, 152 Pilgrim Street, Newcastle-upon-Tyne, N31 6SN" substitute "Unit 5, Greenfinch Way, Newburn Riverside, Newcastle upon Tyne, NE15 8NX"; and

(h) in section 16(16)(b)(ii), after "claim form." insert "Practices can also submit these claims in a digitised format via https://manage-your-service-general-practice.nhsbsa.nhs.uk/".

(6) In Part 5 (vaccines and immunisations)—

(a) in section 18(2) for "NHS England must pay a Contractor an item of service ("IoS") fee of £10.06 in respect of each dose of vaccine or immunisation administered to a patient who" substitute—

"NHS England must pay a Contractor an item of service ("IoS") fee of £12.06 in respect of each dose of vaccine or immunisation set out in Table 1 and £10.06 in respect of each dose of vaccine or immunisation set out in Tables 2 and 3 administered to a patient who -" ;

(b) in section 18(2)(a), after "Contractor" insert "at the data extraction date following the end of the monthly reporting period";

(c) in section 18(4), for "1-4" substitute "1-3";

(d) in section 18(5)(a), for "1st April 2024" substitute "1st April 2025", and for "1st April 2025" substitute "1st April 2026";

(e) in section 18(5)(b), after "patients" insert "at the data extraction date following the end of the monthly reporting period";

(f) in section 18(5)(b)(i), for "the Contractor" substitute "a Contractor";

(g) after section 18(11), insert—

"(12A) NHS England may accept a claim if the vaccination or immunisation was administered to a patient who died during the monthly reporting period or prior to the data extraction date following the end of the monthly reporting period";

(h) in section 19(1), for "1-4" substitute "1-3";

(i) in section 19(2), for "The vaccines and immunisations listed in Tables 1 to 4 below are eligible for an item of service ("IoS") fee of £10.06." substitute—

"The vaccines and immunisations listed in Table 1 (Childhood Routine Immunisations) are eligible for an item of service ("IoS") fee of £12.06."

"Vaccines and immunisations listed in tables 2 and 3 are eligible for an IoS fee of £10.06"

"IoS fees for new vaccination programmes or offers will be determined at the point at which that offer is introduced.";

(j) in section 19(3), for table 1 substitute—

"**Table 1:**

Age	Disease	Vaccine given	Usual Site	Type of Offer
At birth, four weeks	Babies born to hepatitis B infected mothers	Hepatitis B (Engerix B/HBvacPRO)	Thigh	Call/recall
Children aged 12 months on or before 30 June 2025 will be eligible for HepB at their 12-month appointment (whenever	Babies born to hepatitis B infected mothers. Gp practices need to ensure that the results of the baby's blood test to ascertain the existence of Hepatitis B infection is recorded in the baby's patient record	Hepatitis B (Engerix B/HBvacPRO)	Thigh	Call/recall

Age	Disease	Vaccine given	Usual Site	Type of Offer
they present)				
Eight weeks	Diphtheria, tetanus, pertussis, polio, Haemophilus influenzae type b (Hib) and hepatitis B	DtaP/IPV/Hib/HepB	Thigh	Call/recall
	Meningococcal group b (MenB)	MenB	Left thigh	Call/recall
	Rotavirus gastroenteritis	Rotavirus	Mouth	Call/recall
Twelve weeks	Diphtheria, tetanus, pertussis, polio, Haemophilus influenzae type b (Hib) and hepatitis B	DtaP/IPV/Hib/HepB	Thigh	Call/recall
	Pneumococcal (13 serotypes)	Pneumococcal conjugate vaccine (PCV)	Thigh	Call/recall
	Rotavirus	Rotavirus	Mouth	Call/recall
16 weeks	Diphtheria, tetanus, pertussis, polio, Haemophilus influenzae type b (Hib) and hepatitis B	DtaP/IPV/Hib/HepB	Thigh	Call/recall
	MenB	MenB	Left thigh	Call/recall
Under 1 year	Pneumococcal (13 serotypes) immunocompromised or who have complement deficiency, asplenia or splenic dysfunction must receive the PVS and Hib/MenC as follows	PCV first set of doses (2 injections 8 weeks apart)	Thigh	Call/recall
One year (on or after the child's first birthday)	Hib and MenC. Those children who turn 12 months on or before 30 June 2025 (Hib/MenC vaccinations for	Hib/MenC (combined vaccine) until stocks have depleted	Upper arm/thigh	Call/recall

Age	Disease	Vaccine given	Usual Site	Type of Offer
	children who turn 12 months on or after 1 July 2025 will cease)			
	Pneumococcal	Pneumococcal conjugate vaccine (PCV booster)	Upper arm/thigh	Call/recall
	Pneumococcal (13 serotypes) immunocompromised or who have complement deficiency, asplenia or splenic dysfunction must receive the PVS and Hib/MenC as follows	PCV second set of doses (2 injections 8 weeks apart)	Upper arm/thigh	Call/recall
	Measles, Mumps and Rubella	MMR	Upper arm/thigh	Call/recall
	MenB	MenB booster	Left thigh	Call/recall
6 years and over (unknown or incomplete vaccination history where clinically indicated)	Measles, Mumps and Rubella	MMR	Thigh	Opportunistic or if requested. If requested and only if considered to be at high risk of exposure(**a**)
Three years four months or soon after	Diphtheria, tetanus, pertussis and polio	dTap/IPV or DtaP/IPV	Upper arm	Opportunistic or if requested
	Measles, Mumps and Rubella	MMR (check first dose given)	Upper arm	Call/recall
Fourteen years	Tetanus, diphtheria and polio	Td/IPV (check MMR status)	Upper arm	Opportunistic or if requested”

(k) in section 19(4), for “1-4” substitute “1-3”.

(l) in section 19(6), for table 2 substitute—

(**a**) The decision on when to vaccinate older adults needs to take into consideration the past vaccination history, the likelihood of an individual remaining susceptible and the future risk of exposure and disease. Individuals born before 1970 are likely to have had all three natural infections and are less likely to be susceptible. MMR vaccine should only be offered to such individuals on request or if they are risk assessed to be at high risk of exposure.

"**Table 2:**

Age	Disease	Vaccine given	Type of offer
Pregnant women from 16 weeks of pregnancy	Pertussis	ADACEL (Tdap) dTap/IPV(Boostrix - IPV or Repavax)(**a**)	Opportunistic or if requested
2-64 years (in a clinical at risk group)	Pneumococcal (23 serotypes)	Pneumococcal Polysaccharide Vaccine (PPV)	call/recall if in a defined clinical risk group
65 years	Pneumococcal (23 serotypes)	Pneumococcal Polysaccharide Vaccine (PPV)	Call at 65 years old if not in a defined clinical risk group. Opportunistic offer or if requested thereafter
50 years and over at the point of vaccination who fall within a severely immunocompromised cohort, including those individuals 70-79 years contraindicated to Zostavax	Shingles	Shingrix (2 dose schedule, second dose 8 weeks to 6 months after the first)	Call/recall when become eligible. Opportunistic or if requested
Age 65,66 and 67 on or after 1 September 2023 and at the point of vaccination who are immunocompetent individuals, eligible until aged 69 (catch up programme 65-69)	Shingles	Shringrix (2 dose schedule, second dose 6 to 12 months after the first)	Call/recall Opportunistic
Age 70 years on or after 1 September 2023 and at the point of vaccination who are immunocompetent individuals, eligible until aged 80 years (routine programme)	Shingles	Shingrix (2 dose schedule, second dose 6 to 12 months after the first)	Call/recall when become eligible. Opportunistic or if requested until aged 80 years
Aged 75 years on or after 1 September 2024 and at least 75 years at the point of vaccination, remaining	Respiratory Syncytial Virus (RSV)	1 dose of RSV	Call/recall when become eligible. Opportunistic or if

(**a**) Boostrix-IPV or REPEVAX should be given to pregnant women if they have a known severe latex allergy or where ADACEL is not available and to obtain it would result in a delay in vaccination.

Age	Disease	Vaccine given	Type of offer
eligible until attaining age 80 years			requested until aged 80 years
Aged 75-78 years on 31 August 2024 and at the point of vaccination, remaining eligible until attaining 80 years	Respiratory Syncytial Virus (RSV)	1 dose of RSV	Call/recall at the earliest opportunity and prior to 31 August 2025 Opportunistic or if requested thereafter until aged 80 years
Aged 79 years on 31 August 2024 and eligible until 31 August 2025	Respiratory Syncytial Virus (RSV)	1 dose of RSV	Call/recall at the earliest opportunity and prior to 31 August 2025
Individuals who are pregnant from 28 weeks	Respiratory Syncytial Virus (RSV)	1 dose of RSV	Opportunistic or if requested"

(m) in section 19(7), omit table 3.

(n) in section 19(8), for table 4, substitute—

"Table 3:

Age	Disease	Vaccine Given	Type of Offer
14 to 24 years (catch-up, where not administered under the schools programme)	Meningococcal groups A,C,W and Y disease (completing dose)	MenACWY	Opportunistic or if requested
14 to 24 years (where the individual was eligible to receive the vaccine under routine schools immunisation programme but missed vaccination under the schools programme)	Human papillomavirus (HPV) types 16 and 18 (and genital warts cause by types 6 and 11) (completing dose) - until depleted	HPV	Opportunistic or if requested
14 to 24 years (where the individual was eligible to receive the vaccine under routine schools immunisation programme but missed vaccination under the schools programme) N.B Eligibility includes girls born after 1 September	Human papillomavirus (HPV) HPV types (6, 11, 16, 18,31, 33, 45, 52 and 58 - nine valent vaccine)	HPV (2 dose schedule) (1 dose schedule from 1 September 2023 for those who have not received an HPV vaccination)	Opportunistic or if requested

Age	Disease	Vaccine Given	Type of Offer
1991 and boys include males born on or after 1 September 2006			
14 to 24 years immunocompromised individuals (where the individual was eligible to receive the vaccine under routine schools immunisation programme but missed vaccination under the schools programme)	Human papillomavirus (HPV) HPV types (6, 11, 16, 18,31, 33, 45, 52 and 58 - nine valent vaccine)	HPV (a 3 dose schedule is required for immunocompromised individuals)	Opportunistic or if requested"

(7) In Part 5 (vaccines and immunisations)—

(a) in section 19(3), for table 1 substitute—

"Table 1 from 1st July 2025

Age	Disease	Vaccine given	Usual Site	Type of Offer
At birth, four weeks	Babies born to hepatitis B infected mothers	Hepatitis B (Engerix B/HBvacPRO)	Thigh	Call/recall
Children aged 12 months on or before 30 June 2025 will be eligible for HepB at their 12-month appointment (whenever they present)	Babies born to hepatitis B infected mothers. Gp practices need to ensure that the results of the baby's blood test to ascertain the existence of hepatitis B infection is recorded in the baby's patient record	Hepatitis B (Engerix B/HBvacPRO)	Thigh	Call/recall
Eight weeks	Diphtheria, tetanus, pertussis, polio, Haemophilus influenzae type b (Hib) and hepatitis B	DtaP/IPV/Hib/HepB	Thigh	Call/recall
	Meningococcal group b (MenB)	MenB	Left thigh	Call/recall

Age	Disease	Vaccine given	Usual Site	Type of Offer
	Rotavirus gastroenteritis	Rotavirus	Mouth	Call/recall
Twelve weeks	Diphtheria, tetanus, pertussis, polio, Haemophilus influenzae type b (Hib) and hepatitis B	DtaP/IPV/Hib/HepB	Thigh	Call/recall
	MenB	MenB	Left thigh	Call/recall
	Rotavirus	Rotavirus	Mouth	Call/recall
16 weeks	Diphtheria, tetanus, pertussis, polio, Haemophilus influenzae type b (Hib) and hepatitis B	DtaP/IPV/Hib/HepB	Thigh	Call/recall
	Pneumococcal (13 serotypes)	Pneumococcal conjugate vaccine (PCV)	Thigh	Call/recall
Under 1 year	Pneumococcal (13 serotypes) immunocompromised or who have complement deficiency, asplenia or splenic dysfunction must receive the PVS and Hib/MenC as follows	PCV first set of doses (2 injections 8 weeks apart)	Thigh	Call/recall
One year (on or after the child's first birthday)	Hib and MenC. Those children who turn 12 months on or before 30 June 2025 (Hib/MenC vaccinations for children who turn 12 months on or after 1 July 2025 will cease)	Hib/MenC (combined vaccine) until stocks have depleted	Upper arm/thigh	Call/recall
	Pneumococcal	Pneumococcal conjugate vaccine (PCV booster)	Upper arm/thigh	Call/recall
	Pneumococcal (13 serotypes) immunocompromised or who have	PCV second set of doses (2 injections 8 weeks apart)	Upper arm/thigh	Call/recall

Age	Disease	Vaccine given	Usual Site	Type of Offer
	complement deficiency, asplenia or splenic dysfunction must receive the PVS and Hib/MenC as follows			
	Measles, Mumps and Rubella	MMR	Upper arm/thigh	Call/recall
	MenB	MenB booster	Left thigh	Call/recall
Three years four months or soon after	Diphtheria, tetanus, pertussis and polio	dTap/IPV or DtaP/IPV	Upper arm	Opportunistic or if requested
	Measles, Mumps and Rubella	MMR (check first dose given)	Upper arm	Call/recall
6 years and over (unknown or incomplete vaccination history where clinically indicated)	Measles, Mumps and Rubella	MMR	Thigh	Opportunistic or if requested. If requested and only if considered to be at high risk of exposure(**a**)
Fourteen years	Tetanus, diphtheria and polio	Td/IPV (check MMR status)	Upper arm	Call/recall”

(8) In Part 5 (vaccines and immunisations)—

(a) in section 19(6), in the fourth row, substitute—

“Table 2 from 1st September 2025

Age	Disease	Vaccine Given	Type of Offer
18 years and over at the point of vaccination who fall within a severely immunocompromised cohort, including those individuals 70-79 years contraindicated to Zostavax	Shingles	Shingrix (2 dose schedule, second dose 8 weeks to 6 months after the first)	Call/recall when become eligible Opportunistic or if requested”

(**a**) The decision on when to vaccinate older adults needs to take into consideration the past vaccination history, the likelihood of an individual remaining susceptible and the future risk of exposure and disease. Individuals born before 1970 are likely to have had all three natural infections and are less likely to be susceptible. MMR vaccine should only be offered to such individuals on request or if they are risk assessed to be at high risk of exposure.

(9) In Annex A (glossary)—

(a) In Part 2(definitions), in "DES Directions" for "2024" substitute "2025" and for "25th March 2024" substitute "27th March 2025".

(10) In Annex B (global sum)—

(a) in paragraph B.2(d), after "a" insert "CQC registered";

(b) in paragraph B.5, after "patients in" insert "CQC registered" and

(c) in paragraph B.27, after "*age and sex index*" insert "CQC registered".

(11) For Annex D, substitute Annex D as set out in Schedule 2 to these Directions.

(12) In Annex E (calculation of cervical screening achievements points)—

(a) in paragraph E.4, for "£220.62" substitute "£225.49";

(b) in paragraph E.5, for "£220.62" substitute "£225.49".

(13) For Annex F, substitute Annex F as set out in Schedule 3 to these Directions.

(14) After Annex H (dispensary services quality scheme) after paragraph H.23(c) insert—

"ANNEX I

Amendments

(a) The General Medical Services Statement of Financial Entitlements (Amendment) Directions 2024 which were signed on 28th August 2024.

(b) The General Medical Services Statement of Financial Entitlements (Amendment)(No.2) Directions 2024 which were signed on 25th September 2024."

Signed by authority of the Secretary of State for Health and Social Care

Lucy Witter
Member of the Senior Civil Service
Health and Social Care

Department of Health and Social Care, 39
Victoria Street, London SW1H 0EH
Date: 27th March 2025

SCHEDULES

SCHEDULE 1

Direction 2(11)

PART 2

QUALITY AND OUTCOMES FRAMEWORK

GENERAL PROVISIONS RELATING TO THE QUALITY AND OUTCOMES FRAMEWORK

Background

4.—(1) The Quality and Outcomes Framework (QOF) is set out in Annex D to the SFE.

(2) Participation in the QOF is voluntary. Information on what is required to accomplish the task or achieve the outcome included in each indicator is set out in Annex D. Additional Guidance on the rationale for indicators, best practice, establishing evidence and verification is published by NHS England and can be obtained on https://www.england.nhs.uk/gp/investment/gp-contract.

(3) This Section explains the types of payments in relation to the QOF and sets out the mechanism for measuring Achievement Payments in respect of indicators for the financial year commencing on 1st April 2025 and ending on 31st March 2026 – see paragraphs (7) to (20).

Types of payments in relation to the QOF

(4) Essentially, there are two types of payments that are made in relation to the QOF: Aspiration Payments (see also Section 5 (Aspiration Payments: calculation, payment arrangements and conditions of payments)) and Achievement Payments (see also Section 6 (Achievement Payments: calculation, payment arrangements and conditions of payments)).

Aspiration Payments

(5) Aspiration payments are, in effect, a part payment in advance in respect of achievement under the QOF, and may be calculated using one of two different methods—

(a) a calculation based on 80% of the contractor's previous year's Unadjusted Achievement Payment; or

(b) a calculation based on the total number of points that a contractor has agreed with NHS England that it is aspiring towards under the QOF during the financial year in respect of which the Aspiration Payment is made. This total is the contractor's Aspiration Points Total. The points available are set out in the QOF indicators in Annex D, which have numbers of points attached to particular indicators.

(6) If a contractor is to have an Aspiration Points Total, this is to be agreed between the contractor and NHS England—

(a) at the start of the financial year; or

(b) if the contractor's GMS contract takes effect after the start of the financial year, no later than the date the contractor's GMS contract takes effect.

Achievement Payments

(7) Achievement Payments are payments based on the points total that the contractor achieves under the QOF - as calculated, generally speaking (see Section 6(2) (assessment of Achievement

Payments)), on the last day of the financial year or the date on which its contract terminates (see Section 6 (Achievement Payments: calculation, payment arrangements and condition of payments)) - this points total is its Achievement Point Total. The payments are to be made in respect of all Achievement Points actually achieved, whether or not the contractor was seeking to achieve those points, but the final amount also takes into account the deduction of the Aspiration Payments that the contractor has received in respect of the same financial year.

(8) The Achievement Points available by Domain (including Indicator ID prefixes in parentheses) are as follows—

"**Area**	**Total Achievement Points available**
Clinical Domain	
Atrial Fibrillation (AF)	24
Coronary Heart Disease (CHD)	54
Cholesterol Control and Lipid Management (CHOL)	82
Heart Failure (HF)	25
Hypertension (HYP)	52
Stroke and Transient Ischaemic Attack (STIA)	18
Diabetes Mellitus (DM)	78
Asthma (AST)	35
Chronic Obstructive Pulmonary Disease (COPD)	9
Dementia (DEM)	14
Mental Health (MH)	28
Non-diabetic hyperglycaemia (NDH)	18
Public Health Domain	
Blood Pressure (BP)	15
Smoking (SMOK)	37
Vaccinations and Immunisations (VI)	64
Public Health Domain-additional services sub-domain	
Cervical Screening (CS)	11
Totals	**564"**

The domains of the QOF

(9) The QOF is divided into two domains, which are—

(a) the clinical domain;

(b) the public health domain.

Calculation of points in respect of the domains

(10) Each domain contains areas for which there are a number of indicators set out in tables in Section 2 (summary of all indicators) of Annex D. These indicators contain standards (tasks or thresholds) against which the performance of a contractor will be assessed. An explanation of these standards and the calculation relating to these standards are set out in paragraphs (10) to (21).

(11) Indicators have designated Achievement Thresholds. The contractor's performance against the standards set out in these indicators is assessed by a percentage – generally of the patients suffering from a particular disease in respect of whom a specific task is to be performed or a specific outcome recorded (referred to as "fraction"). Two percentages are set in relation to each indicator—

(a) a minimum percentage of patients, which represents the start of the scale; and

(b) a maximum percentage of patients, which is the lowest percentage of eligible patients in respect of whom the task must be performed or outcome recorded in order to qualify for all the points available in respect of that indicator.

(12) If a contractor has achieved a percentage score in relation to a particular indicator that is between the minimum and the maximum set for that indicator, it achieves a proportion of the points available in relation to that indicator. The proportion is calculated as follows:

(13) First, a calculation will have to be made of the percentage the contractor actually scores (D). This is calculated from the following calculation—

(a) First calculate the number produced by subtracting from the total number of patients registered with the contractor with the relevant medical condition (B), the total number of patients who have a personalised care adjustment recorded and the total number of patients who fall within the meaning of excluded patients (C)

(b) Then divide the number of patients registered with the contractor who are part of the cohort described in (14)(a) above and for whom the task has been performed or outcome achieved (A), by the number calculated in (14)(a).

(14) For the purposes of paragraph (14)—

(a) "personalised care adjustment" means an appropriate variation in the care of a registered patient in consequence of which such patients fall within the criteria for personalised care adjustment as set out in paragraphs D.13 to D.22 of Section 1 (introduction) of Annex D; and

(b) "excluded patients" means patients who are on the relevant disease register or target group and are referred to in paragraph D.14 of Section 1 (introduction) of Annex D but are not included in an indicator denominator for the clinical area concerned.

(15) The fraction derived from the calculation in paragraph (15) is then multiplied by 100 for the percentage score. The calculation can be expressed as—

$$\frac{A}{(B - C)} \times 100 = D$$

(16) Once the percentage the contractor actually scores has been calculated (D), subtract from this the minimum percentage score set for that indicator (E), then divide the result by the difference between the maximum (F) and minimum (E) percentage scores set for that indicator, and multiply the result of that calculation by the total number of points available in relation to that indicator (G). This can be expressed as—

$$\frac{(D-E)}{(F-E)} \times G = H$$

(17) The result (H) is the number of points to which the contractor is entitled in relation to that indicator.

Thresholds

(18) Maximum thresholds are intended to be set based on evidence of the maximum practically achievable level to deliver clinical effectiveness. This is to ensure that QOF supports continuous quality improvement year on year up to the level that is practically achievable and will enable more patients to benefit, therefore improving health and saving more lives. Evidence of the maximum practically achievable is to be provided by data available on achievement in previous years.

(19) The percentages for the achievement threshold levels for the fraction indicators included in QOF for the financial year commencing on 1st April 2025 and ending on 31st March 2026 are set out in Annex D.

(20) The percentages for the threshold levels for fraction indicators for the period commencing on 1st April 2025 to 31st March 2026 and the following financial years are to be set according to the following principles—

(a) the thresholds for all continued fraction indicators in the QOF are intended to be reviewed by NHS England each year to decide the level of thresholds for these indicators;

(b) "continued fraction indicators" means fraction indicators that remain in QOF with substantially the same clinical meaning (not necessarily the same points or thresholds) for at least three years – i.e. they were included in the year to which the achievement data relates and they continue in the QOF into the year in which the thresholds are to be amended. For example, for thresholds set for the period commencing on 1st April 2025 and ending on 31st March 2026, to be a continued fraction indicator, an indicator would have had to remain substantially the same in QOF during the three financial years from 1st April 2021 to 31st March 2024; and

(c) a fraction indicator remains "substantially the same" where the clinical meaning remains substantially unchanged in the opinion of the Secretary of State, after seeking advice from NHS England. Where only minor changes to the wording in respect of an indicator is made and the underlying clinical meaning remains the same, then the indicator will be regarded as remaining substantially the same and is a "continued fraction indicator".

ASPIRATION PAYMENTS: CALCULATION, PAYMENT ARRANGEMENTS AND CONDITIONS OF PAYMENTS

Calculation of Monthly Aspiration Payments: General

5.—(1) At the start of each financial year (or if a GMS contract starts after the start of the financial year, the date on which the GMS contract takes effect), subject to sub-paragraph (2)(b), NHS England must calculate for each contractor that has agreed to participate in the QOF the amount of the contractor's Monthly Aspiration Payments for that, or for the rest of that, financial year.

(2) As indicated in Section 4(5) (Aspiration Payments) above, there are two methods by which a contractor's Monthly Aspiration Payments may be calculated. Each contractor may choose the

method by which its Monthly Aspiration Payments are calculated, if it is possible to calculate Monthly Aspiration Payments in respect of the contractor by both methods. However—

(a) if it is only possible to calculate a Monthly Aspiration Payment in respect of the contractor by basing the calculation on an Aspiration Points Total, that is the method which is to be used; and

(b) if the contractor's GMS contract is to take effect on or after 2nd February but before 1st April, no Aspiration Points Total is to be agreed for the financial year into which that 2nd February falls, so the contractor will not be able to claim Monthly Aspiration Payments in that financial year. However, the contractor will nevertheless be entitled to Achievement Payments under the QOF if that contractor participates in the QOF.

Calculation of Monthly Aspiration Payments: the 80% method

(3) Where—

(a) the contractor's GMS contract took effect before the start of the financial year in respect of which the claim for Monthly Aspiration Payments is made; and

(b) in respect of the previous financial year the contractor was entitled to an Achievement Payment under the SFE, that contractor's Monthly Aspiration Payments may be calculated using the 80% method.

(4) To calculate a contractor's Monthly Aspiration Payments by the 80% method, the contractor's Unadjusted Achievement Payment for the previous year needs to be established (that is the total established under Section 6(9) of the 2024/25 SFE as in force on 31st March 2024). Generally, this will not be possible in the first quarter of the financial year, and so a Provisional Unadjusted Achievement Payment will need to be established by NHS England. The amount of this payment is to be based on the contractor's return submitted in accordance with Section 6(4) of the 2024/25 SFE as in force on 31st March 2024 or Section 6(4) (returns in respect of Achievement Payments) of the SFE.

(5) In practice, therefore, the amount of the contractor's Provisional Unadjusted Achievement Payment will be a provisional value for the contractor's Unadjusted Achievement Payment.

(6) Once an annual amount for the contractor's Provisional Unadjusted Achievement Payment has been determined, this is to be multiplied by the Quality and Outcomes Framework Uprating Index for the financial year. The Quality and Outcomes Framework Uprating Index is to be determined by dividing—

(a) the amount set out in Section 6(8) (calculation of Achievement Points) as the value of each Achievement Point for the financial year in respect of which the claim for Monthly Aspiration Payments is being made; by

(b) the amount set out in Section 6(8) (calculation 2024/25 SFE of Achievement Points) or, as the case may be in accordance with Section 6(8) of the 2024/25, as the value of each Achievement Points for the previous financial year,

and the resultant figure is to be multiplied by the CPI. For the purposes of calculating the CPI, the national average practice population figure for the financial year ending 31st March 2026 is 10,184(**a**).

(7) The total produced by paragraph (6) is then to be multiplied by 80%. This figure is then further multiplied by the figure which is the product of the maximum number of points available under the QOF for the financial year in respect of which the calculation is being made divided

(a) The national average practice population figure is taken from the Calculating Quality Reporting Service (CQRS) on 1st January 2024.

by the maximum number of points available under the QOF in the previous financial year. By way of example—

(a) the figures used for this element of the calculation in the financial year commencing on 1st April 2024 and ending on 31st March 2025 were 900 and 1000 respectively, 900 points being the maximum number of points available under the QOF for that financial year and 1000 being the maximum number of points available under the QOF for the financial year commencing on 1st April 2023 and ending on 31st March 2024. The resulting figure is the annual amount of the contractor's Aspiration Payment. This is then to be divided by twelve for what, subject to paragraphs (8), (9) and (10), is to be the contractor's Monthly Aspiration Payment as calculated by the 80% method.

(8) Once the correct amount of the contractor's Achievement Payment in respect of the previous financial year has been established, the amount of the Monthly Aspiration Payments of a contractor whose payments were calculated using a Provisional Unadjusted Achievement Payment is to be revised. First, the difference between the contractor's Total Aspiration Payment for the financial year using the Unadjusted Achievement Payment and Total Aspiration Payment for the financial year calculated using the contractor's Provisional Unadjusted Achievement Payment is to be established. If this figure is zero, there is to be no change to the contractor's Monthly Aspiration Payments for the rest of the financial year.

(9) If contractor's Total Aspiration Payment for the financial year using the Unadjusted Achievement Payment is lower than the Total Aspiration Payment for the financial year calculated using the contractor's Provisional Unadjusted Achievement Payment, the difference between the two is to be divided by the number of complete months left in the financial year after the actual Achievement Payment is paid. The amount produced by that calculation is to be deducted from each of the contractor's Monthly Aspiration Payments in respect of those complete months, thus producing the revised amount of that contractor's Monthly Aspiration Payments for the rest of the financial year.

(10) If the contractor's Total Aspiration Payment for the financial year using the Unadjusted Achievement Payment is higher than the Total Aspiration Payment for the financial year calculated using the contractor's Provisional Unadjusted Achievement Payment, the difference between the two is to be divided by the number of complete months left in the financial year after the actual Achievement Payment is paid. The amount produced by that calculation is to be added to each of the contractor's Monthly Aspiration Payments in respect of those complete months, thus producing the revised amount of that contractor's Monthly Aspiration Payments for the rest of the financial year.

Calculation of Monthly Aspiration Payments: the Aspiration Points Total method

(11) Any contractor who is participating in the QOF may instead have their Monthly Aspiration Payments calculated by the Aspiration Points Total method, provided that the contractor's GMS contract takes effect before 2nd February in the financial year in respect of which the claim for Monthly Aspiration Payments is made.

(12) If the contractor is to have its Monthly Aspiration Payments calculated by this method, at the start of each financial year – or if a GMS contract starts after the start of the financial year, on the date on which the GMS contract takes effect – an Aspiration Points Total is to be agreed between the contractor and NHS England. As indicated in Section 4(5)(b) (Aspiration Payments) above, an Aspiration Points Total is the total number of points that the contractor has agreed with NHS England that it is aspiring towards under the QOF during the financial year in respect of which the Aspiration Payment is made.

(13) If NHS England and the contractor have agreed an Aspiration Points Total for the contractor, that total is to be divided by three. The resulting figure is to be multiplied by £225.49 and then by the contractor's CPI, which produces the annual amount of the contractor's Aspiration Payment. This is then to be divided by twelve for what, subject to Section 6(12) (recovery where Aspiration Payments have been too high), is to be the contractor's Monthly Aspiration Payment, as calculated by the Aspiration Points Total method.

Payment arrangements for Monthly Aspiration Payments

(14) If, as regards any financial year, a contractor could have its Monthly Aspiration Payments calculated by either the 80% method or the Aspiration Points Total method, it must choose the method by which it wishes its Monthly Aspiration Payments to be calculated. Once the contractor has made that choice, the contractor cannot change that choice during that financial year.

(15) NHS England must pay the contractor under the contractor's GMS contract its Monthly Aspiration Payment monthly. The Monthly Aspiration Payment is to fall due on the last day of each month. However, if the contractor's contract took effect on a day other than the first day of a month, the contractor's Monthly Aspiration Payment in respect of that first part month (which will have been calculated by the Aspiration Points Total method) is to be adjusted by the fraction produced by dividing—

(a) (a) the number of days during the month in which the contractor was participating in the QOF; by

(b) (b) the total number of days in that month.

(16) The amount of a contractor's Monthly Aspiration Payments is thereafter to remain unchanged throughout the financial year, even when the contractor's CPI changes and as a consequence is less likely to achieve the Aspiration Points Total that has been agreed.

Conditions attached to Monthly Aspiration Payments

(17) Monthly Aspiration Payments, or any part thereof, are only payable if the contractor satisfies the following conditions—

(a) as regards Monthly Aspiration Payments which are, or are to be, calculated by the Aspiration Points Total method—

(i) the contractor's Aspiration Points Total on which the Payments are based must be realistic and agreed with NHS England, and

(ii) the contractor must make any returns required of it (whether computerized or otherwise) to NHS England in such manner as NHS England may reasonably require, and do so promptly and fully;

(b) the contractor must make available to NHS England any information which NHS England does not have but needs, and the contractor either has or could reasonably be expected to obtain, in order to calculate the contractor's Monthly Aspiration Payments;

(c) a contractor utilising computer systems approved by NHS England must make available to NHS England aggregated monthly returns relating to the contractor's achievement of the standards contained in the indicators in the QOF, and in the standard form provided for by such systems;

(d) a contractor not utilising computer systems approved by NHS England must make available to NHS England similar monthly returns, in such form as NHS England may reasonably request (for example, NHS England may reasonably request that a contractor

fill in manually a printout of the standard spreadsheet in a form specified by NHS England); and

(e) all information supplied pursuant to or in accordance with this paragraph must be accurate.

(18) If the contractor breaches any of the conditions referred to in paragraph (17), NHS England may, in appropriate circumstances, withhold payment of any or any part of a Monthly Aspiration Payment that is otherwise payable.

ACHIEVEMENT PAYMENTS: CALCULATION, PAYMENT ARRANGEMENTS AND CONDITIONS OF PAYMENTS

Basis of Achievement Payments

6.—(1) Achievement Payments are to be based on the Achievement Points to which a contractor is entitled each financial year, as calculated in accordance with this Section and Section 3 (Global Sum payments).

Assessment of Achievement Payment

(2) Subject to paragraph (3), the date in respect of which the assessment of Achievement Points is to be made is the last day of the financial year.

Assessment of Achievement Payments where a GMS contract terminates during the financial year

(3) In a case where a GMS contract terminates before the end of the financial year, the assessment of the Achievement Points to which the contractor is entitled is to be made in respect of the last date in the financial year on which that contractor is required under the contractor's GMS contract to provide Essential Services.

Returns in respect of Achievement Payments

(4) In order to make a claim for an Achievement Payment, a contractor must make a return in respect of the information required by NHS England in order for NHS England to calculate the contractor's Achievement Payment. Where a GMS contract terminates before the end of the financial year, a contractor may make a return at the time the contract terminates in respect of the information necessary to calculate the Achievement Payment to which the contractor is entitled in respect of that financial year.

(5) On the basis of that return but subject to any revision of the Achievement Points Totals that NHS England may reasonably see fit to make to correct the accuracy of any points total, NHS England must calculate the contractor's Achievement Payment as follows.

Calculation of Achievement Payments

(6) The parts of the Achievement Payment that relate to the domains referred to in Section 4(10)(a) and 4(10)(b) (the principal domains of the QOF) are calculated as follow. As regards—

(a) the cervical screening indicators, the Achievement Points Total is to be assessed in accordance with Annex E, and a calculation is to be made of the cash total in respect of those indicators in the manner set out in that Annex; and

(b) the clinical domain and the public health domain in a case where there is a disease register, first a calculation needs to be made of an Adjusted Practice Disease Factor for

each disease area. The sum from this calculation is then multiplied by £225.49 and by the contractor's Achievement Points Total in respect of the disease area to produce a cash amount for that disease area. Then the cash totals in respect of all the individual disease areas in the domain are to be added together to give the cash total in respect of the domain.

A fuller explanation of the calculation of Adjusted Practice Disease Factors, and of the provisions that apply in the case of a GMS contract that only has effect for part of a financial year, is given in Annex F (Adjusted Practice Disease Factor Calculations).

(7) The part of the Achievement Payment that relates to—

(a) indicator SMOK004 in the smoking area of the public health domains; and

(b) indicator BP002 in the blood pressure area of the public health domain, must be calculated by multiplying the total number of Achievement Points gained by the contractor in respect of the indicators referred to in sub-paragraphs (a) and (b) by £225.49.

(8) As regards all the other Achievement Points gained by the contractor, the total number of Achievement Points is to be multiplied by £225.49.

(9) The cash totals produced under paragraphs (6), (7) and (8) are then added together and multiplied by the contractor's CPI, calculated in accordance with the provisions of Section 3(19) (Contractor Population Index)—

(a) at the start of the final quarter of the financial year to which the Achievement Payment relates;

(b) if its GMS contract takes effect after the start of the final quarter of the financial year to which the Achievement Payment relates, on the date its GMS contract takes effect; or

(c) if its GMS contract has been terminated, its CPI at the start of the quarter during which its GMS contract was terminated.

(10) If the contractor's GMS contract had effect—

(a) throughout the financial year, the resulting amount is the interim total for the contractor's Achievement Payment for the financial year; or

(b) for only part of the financial year, the resulting amount is to be adjusted by the fraction produced by dividing the number of days during the financial year for which the contractor's GMS contract had effect by 365 (or 366 where the financial year includes 29th February), and the result of that calculation is the interim total for the contractor's Achievement Payment for the financial year.

(11) From these interim totals, NHS England needs to subtract the total value of all the Monthly Aspiration Payments made to the contractor under its GMS contract in the financial year to which the Achievement Payment relates. The resulting amount (unless it is a negative amount or zero, in which case no Achievement Payment is payable) is the contractor's Achievement Payment for that financial year.

Recovery where Aspiration Payments have been too high

(12) If the resulting amount from the calculation under paragraph (11) is a negative amount, that negative amount, expressed as a positive amount ("the paragraph (11) amount"), is to be recovered by NHS England from the contractor in one of two ways—

(a) to the extent that it is possible to do so, the paragraph (11) amount is to be recovered by deducting one twelfth of that amount from each of the contractor's Monthly Aspiration

Payments for the financial year after the financial year to which the paragraph (9) amount relates. In these circumstances—

(i) the gross amount of its Monthly Aspiration Payments for accounting and superannuation purposes in the financial year after the financial year to which the paragraph (11) amount relates is to be the amount to which the contractor is otherwise entitled under Section 5(3) to 5(10) (calculation of Monthly Aspiration Payments: the 80% method) or Section 5(11) to 5(13) (calculation of Monthly Aspiration Payments: the Aspiration Points Total method), and

(ii) the paragraph (11) amount is to be treated for accounting and superannuation purposes as an overpayment in respect of the contractor's Monthly Aspiration Payments for the financial year to which the paragraph (9) amount relates; or

(b) if it is not possible to recover all or part of the paragraph (11) amount by the method described in sub paragraph (a) (for example, because of the termination of the GMS contract after a partnership split), the amount that cannot be so recovered is to be treated as an overpayment in respect of the contractor's Monthly Aspiration Payments for the year to which the paragraph (9) amount relates, and is to be recovered accordingly (i.e. in accordance with Section 22(1) (overpayments and withheld amounts)).

Accounting arrangements and due date for Achievement Payments

(13) The contractor's Achievement Payment, as calculated in accordance with paragraph (11) is to be treated for accounting and superannuation purposes as gross income of the contractor in the financial year into which the date in respect of which the assessment of Achievement Points on which the Achievement Payment is based ("the relevant date") falls and the Achievement Payment is to fall due—

(a) (a) where the GMS contract terminates before the end of the financial year into which the relevant date falls (see paragraph (3)), at the end of the quarter after the quarter during which the GMS contract was terminated, and

(b) (a) in all other cases, at the end of the first quarter of the financial year after the financial year into which the relevant date falls (see paragraph (2)).

Conditions attached to Achievement Payments

(14) Achievement Payments, or any part thereof, are only payable if the contractor satisfies the following conditions—

(a) the contractor must make the return required of it under paragraph (4);

(b) the contractor must ensure that all the information that it makes available to NHS England in respect of the calculation of its Achievement Payment is based on accurate and reliable information, and that any calculations it makes are carried out correctly;

(c) the contractor must ensure that it is able to provide any information that NHS England may reasonably request of it to demonstrate that it is entitled to each Achievement Point to which it says it is entitled, and the contractor must make that information available to NHS England on request;

(d) the contractor must make any returns required of it (whether computerized or otherwise) to NHS England in such manner as NHS England may reasonably require, and do so promptly and fully;

(e) (e) the contractor must co-operate fully with any reasonable inspection or review that NHS England or another relevant statutory authority wishes to undertake in respect of the Achievement Points to which it says it is entitled; and

(f) all information supplied pursuant to or in accordance with this paragraph must be accurate.

(15) If the contractor breaches any of these conditions, NHS England may, in appropriate circumstances, withhold payment of all or part of an Achievement Payment that is otherwise payable.

SCHEDULE 2

Direction 2(9)

ANNEX D

Quality and Outcomes Framework

SECTION 1: Introduction

General

D1 The Quality and Outcomes Framework (QOF) rewards contractors for the provision of quality care and helps to standardise improvements in the delivery of primary medical services. Contractor participation in QOF is voluntary.

D2 The percentages for the achievement threshold levels for the fraction indicators included in QOF for the financial year commencing on 1st April 2025 and ending on 31st March 2026 are set out in this Annex.

Glossary of terms used in Annex D

Abbreviation	*Definition*
ACE-Inhibitor or ACE-I	Angiotensin Converting Enzyme Inhibitor
AF	Atrial Fibrillation
ARB	Angiotensin Receptor Blocker
AST	Asthma
BMI	Body Mass Index
BP	Blood Pressure
CHD	Coronary Heart Disease
CHADS2	Congestive (HF) Hypertension Age (75 and over) Diabetes Stroke
CKD	Chronic Kidney Disease
CON	Contraceptive
COPD	Chronic Obstructive Pulmonary Disease
CS	Cervical Screening
CVD	Cardiovascular Disease
CVD-PP	CVD Primary Prevention
DEM	Dementia

Abbreviation	*Definition*
DM	Diabetes Mellitus
DXA	Dual-energy X-ray Absorptiometry
FEV1	Forced Expiratory Volume in One Second
GP	General Practitioner
GPPAQ	GP Physical Activity Questionnaire
HbA1c	Glycated Haemoglobin
HF	Heart Failure
HYP	Hypertension
IFCC	International Federation of Clinical Chemistry and Laboratory Medicine
LVSD	Left Ventricular Systolic Dysfunction
MH	Mental Health
mmHg	Millimetres of Mercury
mmol/l	Millimoles per Litre
NICE	National Institute for Health and Care Excellence
SMOK	Smoking
STIA	Stroke and Transient Ischemic Attack
TIA	Transient Ischemic Attack

Interpretation of words and expressions used in Annex D

D.3 In this Annex, unless the context otherwise requires, words and expressions have the following meaning—

(a) "currently treated" in respect of a patient is to be construed as a patient who has been prescribed a specified medicine within a period of six months which ends on the last day of the financial year to which the Achievement Payment relates;

(b) "exclusions" means persons who fall within the description of patient in paragraph D.13;

(c) "financial year" means the period of 12 months commencing on 1st April and ending on 31st March; and

(d) "personalised care adjustment" means an appropriate variation in the care of a registered patient that is recorded in the patient record in consequence of which such patients fall within the criteria for personalised care adjustment set out in paragraphs D.12 to D.22 (personalised care adjustment).

Indicators:general

D.4 For the purposes of calculating Achievement Payments, contractor achievement against QOF indicators is measured—

(a) on the last day of the financial year (31st March); or

(b) in the case where the contract terminates mid-year, on the last day on which the contract subsists.

D.5 For example, for payments relating to the financial year 1st April 2023 to 31st March 2024, unless the contract terminates mid-year, achievement is measured on 31st March 2024. If the GMS contract ends on 30th June 2024, achievement is measured on 30th June 2024.

D.6 Indicators generally set out the target, intervention or measurement to be recorded within a specified time period to establish eligibility for Achievement Payments. Unless otherwise stated, time periods referred to mean the period which ends on the last day of the financial year to which the Achievement Payment relates. For example—

(a) in indicator HYP008, "the percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (or equivalent home blood pressure reading)," the phrase "the preceding 12 months" means the period of 12 months which ends on 31st March in the financial year to which the Achievement Payments relate;

(b) in indicator DM014 the percentage of patients newly diagnosed with diabetes, on the register in the preceding 1st April to 31st March who have a record of being referred to a structured education programme within 9 months after entry in the diabetes register; and

(c) in indicator 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", the phrase "in the previous 3 years and 6 months" means the period of 3 years and 6 months which ends on 31st March in the financial year to which the Achievement Payments relate.

D.7 In the case of a contract that has come to an end before 31 March in any relevant financial year, the reference to periods of time must be calculated on the basis that the period ends on 31st March in the financial year to which the Achievement Payments relate.

Disease registers

D.8 Disease registers are lists of patients registered with the contractor who have been diagnosed with the disease or risk factor described in the register indicator. While it is recognised that these may not be completely accurate, it is the responsibility of the contractor to demonstrate that it has systems in place to maintain a high-quality register. Verification may involve asking how the register is constructed and maintained. NHS England may compare the reported prevalence with the expected prevalence and ask contractors to explain any reasons for variations.

D.9 The purpose of a register in QOF is to define a cohort of patients with a particular condition or risk factor. In some cases, this register then informs other indicators in that disease area. QOF registers must not be used as the sole input for the purposes of individual patient care and clinical audit, i.e. the call and recall of patients for check-ups, treatments etc. There are patients for whom a particular treatment activity is clinically appropriate but they might not meet the criteria as defined by the QOF register and therefore would not be picked up by a search based solely on the QOF register. As such, although QOF registers can be used to supplement clinical audit, they should be supported by appropriate clinical judgement to define which patients should be reviewed, invited for consultation etc. to ensure patients do not miss out on appropriate and sometimes critical care.

D.10 For some indicators, there is no disease register, but instead there is a target population group. For example, for cervical screening the target population group is women who have attained the age of 25 years or over and who have not attained the age of 65 years. Indicators in the

Clinical and Public Health Domain are arranged in terms of clinical areas. Most of these areas either relate to a register or to a target population group.

D.11 Some areas in the clinical domain and the public health domain do not have a register indicator, or there may be more than one register to calculate the Adjusted Practice Disease Factor for different indicators within the area. For all relevant areas, the register population used to calculate the Adjusted Practice Disease Factor are set out in the summary of indicators.

D.12 Whilst the disease register indicators have been retired and so will not attract QOF points in 2025/26, many of them will continue to provide the basis on which ADPF is calculated for remaining indicators. The table below lists the disease register indicators and the fraction indicators that they are used in.

Table of Register Indicators

Retired ID	Disease register indicator	Used to calculate ADPF in indicator
AF001	The contractor establishes and maintains a register of patients with atrial fibrillation	AF006, AF008
CHD001	The contractor establishes and maintains a register of patients with coronary heart disease	CHD005, CHD015, CHD016
HF001	The contractor establishes and maintains a register of patients with heart failure	HF003, HF006, HF007, HF008
HYP001	The contractor establishes and maintains a register of patients with established hypertension	HYP008, HYP009
PAD001	The contractor establishes and maintains a register of patients with peripheral arterial disease	
STIA001	The contractor establishes and maintains a register of patients with stroke or TIA	STIA007, STIA014, STIA015
DM017	The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed	DM006, DM012, DM014, DM020, DM021, DM034, DM035, DM036
AST005	The contractor establishes and maintains a register of patients with asthma aged 6 years or over, excluding patients with asthma who have been prescribed no asthma related drugs in the preceding 12 months	AST007, AST008, AST012
COPD015	(1) The contractor establishes and maintains a register of: (2) Patients with a clinical diagnosis of COPD before 1 April 2023; and (3) Patients with a clinical diagnosis of COPD on or after 1 April 2023 whose diagnosis has been confirmed by a quality assured post-bronchodilator spirometry FEV1/FVC ration below 0.7 between 3 months before or 6 months after diagnosis (or if newly registered at the practice in the preceding 12 months without a record of spirometry having	COPD010, COPD014

Retired ID	Disease register indicator	Used to calculate ADPF in indicator
	been performed, a record of an FEV1/FVC ration below 0.7 recorded within 6 months of registration); and (4) Patients with a clinical diagnosis of COPD on or after 1 April 2023 who are unable to undertake spirometry	
DEM001	The contractor establishes and maintains a register of patients diagnosed with dementia	DEM004
MH001	The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy	MH002, MH003, MH006, MH007, MH011, MH012, MH021
CAN001	The contractor establishes and maintains a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers diagnosed on or after 1 April 2003'	CAN004, CAN005
CKD005	The contractor establishes and maintains a register of patients aged 18 or over with CKD with classification of categories G3a to G5 (previously stage 3 to 5)	
EP001	The contractor establishes and maintains a register of patients ages 18 or over receiving drug treatment for epilepsy	
LD004	The contractor establishes and maintains a register of patients with learning disabilities	
OST004	(1) The contractor establishes and maintains a register of patients: (2) Aged 50 or over and who have not attained the age of 75 with a record of a fragility fracture on or after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and (3) Aged 75 or over with a record of a fragility fracture on or after 1 April 2014 and a diagnosis of osteoporosis	
RA001	The contractor establishes and maintains a register of patients aged 16 or over with rheumatoid arthritis	
PC001	The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age	
OB003	The contractor establishes and maintains a register of patients aged 18 years or over living with obesity, appropriately adjusted for ethnicity in line with NICE guidelines-either with a BMI greater than or equal to 30kg/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	

Personalised care adjustment (formerly Exception reporting) and exclusions

D.13 Personalisation of care applies to those indicators in any domain of QOF where the achievement is determined by the percentage of patients receiving the specified level of care (fraction indicators), unless otherwise stated in the QOF Guidance.

D.14 Some indicators refer to a sub-set of patients on the relevant disease register, or in the target population group of a particular indicator. Patients who are on the disease register or target group, but not included in an indicator denominator for the clinical area concerned for definitional reasons are called "exclusions".

D.15 A personalised care adjustment may be applied to the care of a registered patient who is in the relevant disease register or target group and would ordinarily be included in the indicator denominator if they meet one or more of the criteria set out below. Patients are removed from the denominator if their care has been personalised and also the care specified in the indicator has not been carried out. If the patient has had a reason for the personalisation of care added to their record but the care has been carried out in the relevant time period then the patient will be included in both the denominator and the numerator.

D.16 A personalised care adjustment cannot remove a patient from the underpinning register or target group and the patient must be included in the calculation of the Adjusted Practice Disease Factor.

D.17 Care may be personalised for the following reasons, listed in the order in which they will be applied in the Business rules—

(a) The investigative or secondary care service is unavailable. This will apply only to AST012 and DM014. Discrete codes which indicate the concept of a service not being available should be used to record this;

(b) The intervention described in the indicator is clinically unsuitable for the patient. This may be due to specific reasons such as the patient being on maximum tolerated doses of medication, allergies, contraindications or other medication intolerances or broader reasons such as it being clinically inappropriate to review disease parameters due to particular circumstances such as being at the end of their life or having a supervening condition against which QOF interventions need to be balanced;

(c) The patient has chosen not to receive the intervention described in the indicator and this has been recorded in their patient record following a discussion with the patient;

(d) The patient has not responded to a minimum of two invitations for the intervention during the financial year to which the Achievement Payments relate except in the case of indicators CS005 and CS006, where the patient should have been invited on at least three occasions during the period specified in the indicator during which the achievement is to be measured (i.e. the preceding 3 years and 6 months or 5 years and 6 months ending on 31st March in the financial year to which Achievement Payments relate). Any and all invitations should be recorded in the patient record when they are made. There should be a minimum of seven days between the first and second invitation; and

(e) The patient has been diagnosed or registered at the practice when it is too late to deliver the intervention described in the indicator during the financial year to which the Achievement Payments relate.

(i) For the majority of indicators this means that the patient has been diagnosed or registered at the practice within the last three months of the financial year.

(ii) (ii) For indicators VI001, VI002 and VI003 this means the patient has been registered when there is not enough time to complete their vaccination course in accordance with the childhood routine immunisation schedule as set out in Part 5 and the requirements of the relevant QOF indicator before they are outside the age

range specified by the relevant QOF indicator or before the end of the financial year.

(iii) For indicators CHD015, CHD016, HYP008, HYP009, STIA014, STIA015, DM020, DM021 and DM036, this means being diagnosed or registered within the last nine months of the financial year.

D.18 Criteria (b) and (c) will be supported by both specific i.e. indicator specific and generic codes i.e. those which record the concept of patient unsuitability and informed dissent. Specific codes will remove the patient from the denominator for individual indicators where these criteria apply e.g. a record of a medication allergy would remove the patient from the denominator of an indicator related to the prescribing of that drug and not all the other clinical indicators in a set. Generic codes will remove the patient from the denominator for all the indicators in that set.

D.19 Criterion (a) will apply to the indicators specified above only and will only remove patients from the denominator of those indicators. Criterion (d) will not apply to indicator HF008.

D.20 Only criteria (b) and (e) will apply to the following indicators: VI001, VI002and VI003.

D.21 Criteria (d) and (e) will remove patients from all indicators in a given set unless the care has subsequently been carried out within the relevant time period as described in paragraph D.6(a) to (d) above.

D.22 Contractors should report the number of patients with a personalised care adjustment recorded for each indicator set and individual indicator. Contractors will not be expected to provide reasons for inclusion of a personalised care adjustment in an individual patient's record.

D.23 Additional guidance on the personalised care adjustment is included in the guidance published by NHS England and can be obtained on https://www.england.nhs.uk/gp/gpfv/investment/gp-contract.

Verification

D.24 The contractor must ensure that it is able to provide any information that NHS England may reasonably request of it to demonstrate that it is entitled to each achievement point to which it says it is entitled, and the contractor must make that information available to NHS England on request. In verifying that an indicator has been achieved and information correctly recorded, NHS England 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.

Section 2: Summary of all indicators

Section 2.1: Clinical domain (437 points)

Section 2.1 applies to all contractors participating in QOF.

Atrial fibrillation (AF)

Indicator	*Points*	*Achievement thresholds*
Ongoing Management		
AF006. The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA_2DS_2-VAS_C score risk stratification scoring system in the preceding 12 months (excluding those	12	40-90%

Indicator	*Points*	*Achievement thresholds*
patients with a previous $CHADS_2$ or CHA_2DS_2-VAS_C score of 2 or more) Based on NICE IND127		
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 Based on NICE IND247	12	70-95%

For AF008, patients with a previous score of 2 or above using $CHADS_2$, recorded prior to 1 April 2015 will be included in the denominator.

Secondary prevention of coronary heart disease (CHD)

Indicator	*Points*	*Achievement 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 Based on NICE IND132	7	56-96%
CHD015. The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (or equivalent home blood pressure reading) Based on NICE IND241	33	40-90%
CHD016. The percentage of patients aged 80 years or over with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less (or equivalent home blood pressure reading) Based on NICE IND242	14	46-90%

Cholesterol control and lipid management (CHOL)

Indicator	*Points*	*Achievement thresholds*
CHOL003. Percentage of patients on the QOF Coronary Heart Disease,	38	70-95%

Indicator	*Points*	*Achievement thresholds*
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 Based on NICE IND230		
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 Based on NICE IND278	44	20-50%

Heart Failure (HF)

Indicator	*Points*	*Achievement thresholds*
Initial diagnosis		
HF008. The percentage of patients with a diagnosis of heart failure on or after 1 April 2023 which: (a) Has been confirmed by an echocardiogram or by specialist assessment in the 6 months before entering on to the register; or (b) 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. Based on NICE IND192	6	50-90%
Ongoing management		

Indicator	*Points*	*Achievement thresholds*
HF003. In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction or whose heart failure is due to reduced ejection fraction, the percentage of patients who are currently treated with an angiotensin-converting enzyme inhibitor ACE-I or Angiotensin II receptor blocker ARB Based on NICE IND193	6	60-92%
HF006. The percentage of patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction or whose heart failure is due to reduced ejection fraction, who are currently treated with a beta-blocker licensed for heart failure Based on NICE IND194	6	60-92%
HF007. The percentage of patients with a diagnosis of heart failure on the register, who have had a review in the preceding 12 months, including an assessment of functional capacity and a review of medication to ensure medicines optimisation at maximal tolerated doses Based on NICE IND195	7	50-90%

Disease registers for heart failure

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

(a) a register of patients with HF is used to calculate APDF for HF008 and HF007,

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

Register 1 is defined in indicator HF001 (see Table of Register Indicators in section 1, annex D).

Register 2 is a sub-set of register 1 and is composed of patients with a diagnostic code for LVSD as well as for HF.

Hypertension (HYP)

Indicator	*Points*	*Achievements thresholds*
Ongoing management		

Indicator	*Points*	*Achievements thresholds*
HYP008. The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (or equivalent home blood pressure reading) Based on NICE IND239	38	40-85%
HYP009. The percentage of patients aged 80 years or over with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less (or equivalent home blood pressure reading) Based on NICE IND240	14	40-85%

Stroke and transient ischaemic attack (STIA)

Indicator	*Points*	*Achievements 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 Based on NICE IND133	4	57-97%
STIA014. The percentage of patients aged 79 years or under with a history of stroke or TIA in whom the least blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (or equivalent home blood pressure reading) Based on NICE IND243	8	40-90%
STIA015. The percentage of patients aged 80 years or over with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less (or equivalent home blood pressure reading)	6	46-90%

Indicator	*Points*	*Achievements thresholds*
Based on NICE IND244		

Diabetes Mellitus (DM)

Indicator	*Points*	*Achievement 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) Based on NICE IND134	3	57-97%
DM012. The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 12 months Based on NICE IND81	4	50-90%
DM014. The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register Based on NICE IND88	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) Based on NICE IND249	27	38-90%
DM020. The percentage of patients with diabetes, on the registers,	17	35-75%

Indicator	*Points*	*Achievement thresholds*
without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months Based on NICE IND179		
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 Based on NICE IND180	10	52-92%
DM034. The percentage of patients with diabetes aged 40 years and over, with no history of cardiovascular disease and without moderate or severe frailty, who are currently treated with a statin (excluding patients with type 2 diabetes and a CVD risk score of <10% recorded in the preceding 3 years) or where a statin is declined or clinically unsuitable, another lipid-lowering therapy. Based on NICE IND275	4	50-90%
DM035. The percentage of patients with diabetes and a history of cardiovascular disease (excluding haemorrhagic stroke) who are currently treated with a statin Based on NICE IND276	2	50-90%

Asthma (AST)

Indicator	*Points*	*Achievement thresholds*
Initial diagnosis		
AST012. The percentage of patients with a new diagnosis of asthma on or after 1 April 2025 with a record of an objective test between 3 months before or 3 months after diagnosis. Based on NICE IND272	15	45-80%
Ongoing management		

Indicator	*Points*	*Achievement thresholds*
AST007. The percentage of patients with asthma on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control, a recording of the number of exacerbations, an assessment of inhaler technique and a written personalised action plan. Based on NICE IND273	20	45-70%

Chronic obstructive pulmonary disease (COPD)

Indicator	*Points*	*Achievement thresholds*
Ongoing management		
COPD010. The percentage of patients with COPD on the register, who have had a review in the preceding 12 months, which included a record of the number of exacerbations and an assessment of breathlessness using the Medical Research Council dyspnoea scale Based on NICE IND191	9	50-90%

Dementia (DEM)

Indicator	*Points*	*Achievements thresholds*
Ongoing management		
DEM004. The percentage of patients diagnosed with dementia whose care plan has been reviewed in the preceding 12 months Based on NICE IND142	14	35-70%

Mental health (MH)

Indicator	*Points*	*Achievements 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	5	40-90%

Indicator	*Points*	*Achievements thresholds*
individuals, their family and/or carers as appropriate Based on NICE IND143		
MH003. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months Based on NICE IND84	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 Based on NICE IND83	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 Based on NICE IND82	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 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 Based on NICE IND158	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 Based on NICE IND159	7	50-90%

Disease register for mental health

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

Remission from serious mental illness

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

(a) no record of anti-psychotic medication

(b) no mental health in-patient episodes; and

(c) no secondary or community care mental health follow-up for at least five years.

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

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

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

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

Non diabetic hyperglycaemia (NDH)

Indicator	*Points*	*Achievement thresholds*
Ongoing management		
NDH002. The percentage of patients with non-diabetic hyperglycaemia who have had an HbA1c or fasting blood glucose performed in the preceding 12 months Based on NICE IND172	18	50-90%

Section 2.2:Public health domain (127 points)

Section 2.2 applies to all contractors participating in QOF.

Blood pressure (BP)

Indicator	*Points*	*Achievements thresholds*
Records		
BP002. The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years Based on NICE IND112	15	50-90%

Smoking (SMOK)

Indicator	*Points*	*Achievement thresholds*
Records		
SMOK002. The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months Based on NICE IND97	25	50-90%
Ongoing management		
SMOK004. The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 24 months Based on NICE IND99	12	40-90%

Disease register for smoking

The disease register for the purpose of calculating the APDF for SMOK002 (see Table of Register Indicators in section 1, annex D) is defined as the sum of the number of patients on the disease registers for each of the conditions listed in the indicators. Any patient who has one or more co-morbidities e.g. diabetes and CHD, is only counted once on the register for SMOK002.

There is no APDF calculation for SMOK004.

Requirements for recording smoking status

Smokers

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

Non-smokers

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

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

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

Ex-smokers

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

Vaccines and Immunisations (VI)

Indicator	Points	Achievements 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 Based on NICE IND215	18	89-96%
VI002. The percentage of children who reached 18 months old in the preceding 12 months, who have received at least 1 dose of MMR between the ages of 12 and 18 months. *Based on NICE IND216*	18	81-96%
VI003. The percentage of children who reached 5 years old in the preceding 12 months, who have received a reinforcing dose of DTaP/IPV and at least 2 doses of MMR between the ages of 1 and 5 years. Based on NICE IND217	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. Based on NICE IND219	10	50-60%

Cervical screening (CS)

Indicator	*Points*	*Achievement thresholds*
CS005. The proportion of women eligible for screening and aged 25-49 years at the end of period reported whose notes record that an adequate cervical screening test has been	7	45-80%

Indicator	*Points*	*Achievement thresholds*
performed in the previous 3 years and 6 months Based on NICE IND176		
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 Based on NICE IND177	4	45-80%

SCHEDULE 3

Direction 2(13)

ANNEX F

Adjusted Practice Disease Factor Calculations

Calculations

F.1 The calculation involves three steps—

(a) the calculation of the contractor's Raw Practice Disease Prevalence. There will be a Raw Practice Disease Prevalence in respect of each indicator in the clinical and public health domains (other than Achievement Points for cervical screening services where achievement is calculated in accordance with Annex E and indicators BP002 and SMOK004);

(b) making an adjustment to give an Adjusted Practice Disease Factor; and

(c) applying the factor to the pounds per point figure for each disease area.

F.2 The above three steps are explained below. Subject to the exceptions specified in Section 2 of Annex D in respect of specific diseases, the register to be used to calculate the Raw Practice Disease Prevalence is the register as set out in Table 2 in Section 2 of Annex D for the area concerned. In the case where there is no register indicator or the register indicator is not the register to be used in respect of a specific disease area or indicator, the applicable register in respect of that specific disease area or indicator is specified in the relevant part of Section 2 of Annex D relating to that disease.

F.3 The Raw Practice Disease Prevalence is calculated by dividing the number of patients on the relevant disease register at 31st March in the financial year to which the Achievement Payment relates by the contractor's CRP for the relevant date. For these purposes, the "relevant date" is the date in respect of which the value of the contractor's CPI that is being used to calculate its Achievement Payment is established. Generally, this is the start of the final quarter of the financial year to which the Achievement Payment relates but, see Section 6(6) to (11) (calculation of Achievement Payments).

F.4 The Adjusted Practice Disease Factor is calculated by—

(a) calculating the national range of Raw Practice Disease Prevalence's in England (NHS England must use the national range established annually through the Calculating Quality Reporting Service (known as CQRS));

(b) re-basing the contractor figures around the new national English mean (available at the end of each month) to give the Adjusted Practice Disease Factor (APDF). For example, an APDF of 1.2 indicates a 20% greater prevalence than the mean, in the adjusted distribution. The re-basing ensures that in the relevant year, the average contractor (that is a contractor with an APDF of 1.00) would receive, after adjustment, an amount per point equal to the amount specified in Section 6(6) to (11) (calculation of Achievement Payments) of the SFE as in force on the 1st April in that relevant year;

(c) thus, adjusting via the factor the contractor's average pounds per point for each disease, rather than the contractor's points score.

F.5 "Relevant year" in paragraph F.4 (b) means the financial year to which the calculation of Achievement Payments relates.

F.6 As a result of the calculation in paragraph F.1, each contractor will have a different "pounds per point" figure for each indicator area with a disease register or may have a different "pounds per point" for individual indicators within an area (if more than one register is used for the area). It will then be possible to use these figures to calculate a cash total in relation to the points scored for each area (other than indicators SMOK004 or BP002).

F.7 This national prevalence figure and range of practice prevalence will be calculated on an England-only basis.

F.8 If the contractor's GMS contract terminates before 1st January in the financial year to which the Achievement Payment relates, the Adjusted Practice Disease Factor to be used in calculating the contractor's Achievement Payment should be the Adjusted Practice Disease Factor calculated for the contractor for the previous financial year.

F.9 If the contractor did not have an Adjusted Practice Disease Factor calculation for the previous financial year, then no Adjusted Practice Disease Factor should be used in calculating the contractor's Achievement Payment for that year.

F.10 Unless paragraph F.11 applies, if the contractor's GMS contract terminates on or after 1st January and before the end of the financial year to which the Achievement Payment relates—

(a) the CRP to be used to calculate the Raw Practice Disease Prevalence is the CRP on 1st January; and

(b) the number of patients on the disease register is to be taken to be the number of patients on the register on the date nearest to the date on which the contract ends and on which there can be a calculation.

F.11 If the contractor's GMS contract commences after 1st January and terminates before the end of the financial year in which the GMS contract commences, no Adjusted Practice Disease Factor is to be calculated for the contractor's Achievement Payment in respect of the period during which the contract subsisted.