The role of the Quality and Outcomes Framework in the care of long-term conditions: a systematic review

INTRODUCTION
The UK’s Quality and Outcomes Framework (QOF) is the world’s largest pay-for-performance scheme in primary care. It rewards general practices financially for delivering interventions and achieving patient outcomes using evidence-based indicators developed by the National Institute for Health and Care Excellence (NICE). Although the QOF is voluntary, nearly 99% of practices in England participate, on average deriving 10–15% of total practice income from the scheme. The introduction of the QOF in 2004 was a part of a new national contract for GPs, driven by the need to respond to years of underinvestment in general practice compared with other parts of the health service, low morale among GPs, and variations in the quality of primary medical care. The QOF was intended to provide a mechanism to motivate GPs and to increase funding for their practices, and the vast majority of practices took up the opportunity for additional income. Evidence from the early years of the scheme suggested it reduced variations between practices in the delivery of incentivised interventions, and contributed to progress towards better use of electronic records and nurse-led multidisciplinary care of long-term conditions. After the first year of the QOF, most practices achieved near-maximum remuneration from the scheme. Arguably, then, the QOF achieved what it set out to do. But this may have come at a cost. It has been suggested that practices prioritise QOF-related activities at the expense of other aspects of care, because of their reliance on QOF income. A decade after the introduction of the QOF, NHS strategy, set out in the 2014 Five Year Forward View, is now focused on other challenges. These include finding new ways to manage people with long-term conditions, whose care is estimated to consume 70% of health service resources. Most clinical QOF indicators relate to the care of long-term conditions and are based on good evidence, but tend to be limited in scope, focusing on single, biomedical dimensions of care. Appendix 1 provides a brief description of the 68 QOF indicators relating to care of long-term conditions in 2016–2017; the total number of indicators for that year was 77.

In 2015, the Royal College of General Practitioners called for the replacement of the QOF to allow GPs ‘to focus on providing the best possible holistic care’. NHS England, in April 2016, undertook to review the QOF, acknowledging that it may have ‘served its purpose’ and may be ‘a barrier to holistic management’. In early 2017, the British Medical Association called for the QOF to be suspended to reduce bureaucratic pressures and free up clinical time. Scotland abolished the QOF in 2016. The Policy Research Unit in Commissioning and the Health Care System was commissioned to undertake a review, led by the Centre for Health Services Research, George Allen Wing, Cornwallis Building, University of Kent, Canterbury, Kent, CT2 7NF, UK. E-mail: L.Forbes@kent.ac.uk Submitted: 10 March 2017; Editor’s response: 10 April 2017; final acceptance: 12 May 2017. ©British Journal of General Practice This is the full-length article (published online 26 Sep 2017) of an abridged version published in print. Cite this version as: Br J Gen Pract 2017; DOI: https://doi.org/10.3399/bjgp17X693077
How this fits in

The usefulness of the Quality and Outcomes Framework (QOF) as a tool for promoting progress towards the vision of the Five Year Forward View for care of long-term conditions has been questioned. This systematic review found no convincing evidence that the QOF can promote better integrated care, personalised, holistic care, or self-care — or, indeed, improve any other outcomes in people with long-term conditions. The NHS should consider other ways of supporting general practice to deliver the vision of the Five Year Forward View.

Studies at the University of Kent, to report in September 2016. The authors aimed to examine the evidence that the QOF has improved care and outcomes for patients with long-term conditions, including elements of care highlighted as priorities in the Five Year Forward View, such as coordinated and integrated care, holistic and personalised care, and self-care.

METHOD

The authors searched for reports of empirical quantitative research examining the effectiveness of the QOF in the management of long-term conditions, published in peer-reviewed journals in English. They included studies of populations registered with GPs in the UK, and excluded studies of locally designed and implemented pay-for-performance schemes, and studies of limited geographical scope (which were defined as examining data from fewer than four primary care trusts in England, or fewer than 100 practices in Scotland) because of likely low generalisability. The authors included studies where the comparator was any other method of funding general practice, concurrent or historical, and, if there was no concurrent comparator, where the analysis controlled for underlying trends. They set no limits on outcomes except that they were measured quantitatively and related to patients with long-term conditions, including:

- measures of health or morbidity: biochemical and physiological measures, mortality, hospital admissions;
- biomedical aspects of delivery of care: diagnostics, plans, referrals, and ongoing monitoring, clinical interventions (for example, prescriptions, immunisations), consultation rates;
- broader aspects of care: coordination, continuity or integration of care, holistic care (that is, that considers multiple morbidity and social context, personalised for the patient), self-care; and
- patient perspectives: patient experience, quality of life, or satisfaction.

The authors included randomised controlled trials, longitudinal studies where the analysis attempted to control for underlying trends, controlled before-and-after studies, and systematic reviews of these. They excluded cross-sectional studies examining how outcomes varied according to QOF achievement, because of the lack of suitable controls, the near-universal high level of achievement, and the high likelihood of confounding of associations between QOF achievement and outcome by other factors. The authors also excluded studies in which the researchers estimated or modelled outcomes rather than reporting empirical data (more details of the inclusion and exclusion criteria are available from the authors). The authors searched electronic databases (Cochrane Database, Medline, Embase, and Health Management Information Consortium) for studies published between 2004 (the year the QOF was introduced) and May 2016 (see Box 1 for search terms). They examined references of identified papers to search for further reports and asked experts for references to other relevant research.

Two of the authors assessed suitability for inclusion for each abstract identified, and, where there was no consensus, asked a third author to adjudicate. Data were extracted independently from all papers by two authors.

The authors assessed quality of randomised controlled trials using adaptations of the Cochrane Collaboration’s tool, and longitudinal studies and systematic reviews using tools adapted from those developed by the National Institutes of Health.

RESULTS

Identification and description of studies

Figure 1 shows the process of identification of studies. The three most recent systematic reviews asking the same questions as this review had search dates in 2012, 2016, and 2015. These included 20 studies of the QOF in total. The systematic review with the 2015 search date identified two studies of the QOF, both of which had been published in 2011 and had been included in one or other of the two reviews with search dates in 2012.

In all three reviews, while the authors set

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Box 1. Search terms

Search 1
- Quality Outcomes Framework (keyword) OR
- Quality and Outcomes Framework (keyword) OR
- QOF (keyword)

Search 2
- Pay-for-performance (keyword) or Reimbursement (Medical Subject Heading (MeSH) term) AND
- Primary health care (keyword) OR Primary Health Care (MeSH term) OR
- Primary medical care (keyword) or Family practice (MeSH term) OR
- General practice (keyword) or General Practice (MeSH term)
few limits on outcomes, study outcomes were solely derived from either QOF indicators themselves or prescribing data, with two exceptions: one study examined adherence to British Thoracic Society spirometry standards and the other cardiovascular events in patients with hypertension.

The authors found five primary research studies meeting the search criteria published since 2012. The first examined trends in mortality rates for conditions covered by the QOF, comparing the UK with other high-income countries with no pay-for-performance schemes. The others examined the effect of introducing the QOF on patient management and outcomes, either nationally or in samples of practices participating in the UK General Practice Research Database (GPRD) or Clinical Practice Research Datalink (CPRD) [627 UK practices, 516 UK practices, 148 English practices].

The studies’ outcomes were: mortality from long-term conditions; hospital admissions for a range of QOF and non-QOF conditions; consultation rates in severe mental illness (SMI); prescribing in type 2 diabetes; and a composite indicator derived from QOF data on processes and outcomes of care in type 2 diabetes. Because of a high degree of study heterogeneity, the authors carried out a narrative synthesis. Table 1 summarises the design and results of primary research studies.

None of the relevant studies identified by the systematic reviews, or the primary studies published since 2012, examined the effect of the QOF on broader aspects of care or patient perspectives.

Quality
The systematic reviews were of good quality. Due to the nature of the intervention, the primary research studies were all before-and-after studies using interrupted time series or difference-in-differences methods and, as such, were of good quality for observational studies. However, because of the study designs, the authors cannot be sure that the QOF was responsible for any change in outcomes.

Findings
Systematic reviews. The first systematic review concluded that the QOF had had a limited impact on health outcomes. The second systematic review concluded that the effect of pay-for-performance remained uncertain. The third systematic review concluded that there was limited evidence of the effects of financial incentives.

Primary research. The study examining trends in mortality in the UK compared with other countries found no effect of the QOF, although the synthetic control approach adopted in the study required the use of conservative tests for statistical inference. The study examining emergency admissions before and after the introduction of the QOF found that the trend of increasing emergency hospital admission rates (which increased overall by 34% between 2004 and 2010) was modestly lower for conditions incentivised in the QOF compared with conditions that were not incentivised in the QOF, by 3% in the first year rising to 8% in 2010. The difference was mainly driven by relative reductions in emergency admission rates for coronary heart disease.

The study examining consultation rates found a trend of increasing rates overall during the period, with a small step change in 2004; the rate of increase was greater in people with SMI than overall. The face-to-face consultation rate in SMI increased from about nine to 11 per patient per year from 2000 to 2011, and in other people it stayed stable at about five per patient per year over the same period.
<table>
<thead>
<tr>
<th>Authors</th>
<th>Year of publication</th>
<th>Geographical area and period under study</th>
<th>Main outcome</th>
<th>Key results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ryan A, et al</td>
<td>2016</td>
<td>Populations of UK and 27 other high income countries, 1994–2010.</td>
<td>Mortality levels from chronic diseases targeted by QOF.</td>
<td>Mortality fell in all countries over the period. QOF not associated with a step change in mortality in the UK. Difference between mortality/100,000 between UK observed and expected –3.7 (95% CI = –8.2 to 0.8).</td>
</tr>
</tbody>
</table>
| Harrison MJ, et al | 2014               | All English practices, 1998–2010         | Rates of emergency admissions: • that can be prevented in the community, including those for — conditions for which care incentivised by QOF — conditions for which care not incentivised by QOF • that cannot be prevented in community care. | Emergency admission rates increased by 34%, but rate of increase lower for conditions for which care incentivised by QOF than other types of emergency admission.  
• In 2003, no difference in emergency admission rates between those for which care is incentivised by QOF and those for which care is not incentivised by QOF.  
• By 2010, rates of emergency admissions for conditions for which care is incentivised by QOF 8% (95% CI = 6.9 to 9.1) lower than those for which care is not incentivised by QOF.  
• By 2010, rates of emergency admissions for conditions for which care is incentivised by QOF 11% (95% CI = 10.1 to 11.7) lower than those that cannot be prevented. The lower increase in emergency admission rates among those for whom care incentivised by QOF was mainly driven by admissions for coronary heart disease. |
• in SMI — increased from 22 to 49 per year (92% increase);  
• people without SMI — increased from 10 to 19 per year (75% increase).  
For both, trend of increasing rates before 2004. Significant step change increase in 2004 for both groups, much bigger step change for people with SMI. After this, rate of increase declined in both groups.  
Face-to-face consultation rate:  
• in people with SMI, nine/patient/year 2000–2003, rising to 11/patient/year in 2011;  
• in people without SMI, about five/patient/year over the whole period. |
| Gallagher N, et al | 2015              | A total of 516 practices in the GPRD across UK, 1999–2008. | The % of newly diagnosed patients with type 2 diabetes prescribed medication within 24 months after diagnosis. | Pre-intervention 1999–2003: rate decreasing by 1.4% per year (95% CI = 0.8 to 2.1). Post-intervention 2004–2008: rate increased by 1.6% per year (95% CI = 0.8 to 2.3). |

CI = confidence interval. CPRD = Clinical Practice Research Datalink. GPRD = General Practice Research Database. QOF = Quality and Outcomes Framework. SMI = severe mental illness.
The study of prescribing in type 2 diabetes found a modest increase in prescribing of antidiabetic medication (changing the direction of the trend of decreasing initiation rates to increasing initiation rates) after the introduction of the QOF.\textsuperscript{41} The increase was sustained at a similar rate until 2008.

The study examining effects on a composite indicator of process and outcomes in type 2 diabetes found a modest improvement of 14\% over and above the underlying trend in the first year after the introduction of the QOF, declining to 8\% in the third year.\textsuperscript{32} Table 1 summarises the results of the studies.

**DISCUSSION**

**Summary**
The authors found evidence that the QOF may be associated with a modest reduction in emergency admission rates in long-term conditions, a modest increase in consultation rates in SMI, and modest improvements in certain limited aspects of the care of diabetes. They found no clear evidence that these changes have led to any effect on mortality. Because of the design of the studies, it is not possible to be sure that any of the positive effects seen are causally related to the QOF.

The authors found no evidence to suggest that the QOF influences, positively or negatively, other aspects of care, such as integration or coordination of care, holistic or personalised care, or self-care, nor any evidence of its effects on patients’ quality of life, experience, or satisfaction.

The QOF is unlikely to advance progress towards the vision of the *Five Year Forward View* for the care of long-term conditions. To deliver the aims of the *Five Year Forward View*, the NHS should consider more broadly — beyond what is measured by the QOF — what constitutes high-quality primary care for people with long-term conditions, and consider managing performance on this basis. In the context of a demoralised primary care workforce, it is important also to consider ways other than financial incentives to motivate primary care teams to deliver high-quality care.

**Strengths and limitations**
To the authors’ knowledge, this review is the first to have specifically addressed the effect of the QOF on those aspects of care for long-term conditions that are prioritised by national policy. As with any systematic review, the authors’ conclusions are constrained by the limited quantity and quality of the primary research published to date. Although the search for quantitative research was comprehensive, the authors did not include qualitative research, which may provide other insights.

Research to date has not attempted to identify the effects of the QOF on any of the broader aspects of care for long-term conditions, having examined effects only on more easily measurable outcomes, for example, those collected as part of the QOF, or routinely available data on mortality, emergency admissions, consultation rates, and prescribing. The authors found no evidence of attempts to evaluate the QOF using validated measures of quality of care in general practice. Perhaps this is because defining and measuring quality of general practice is complex.\textsuperscript{36}

The lack of effect of the QOF on mortality is surprising, given that the indicators are based on high-quality evidence of effectiveness of interventions. Why this is the case is not clear. The wider determinants of population health (including low income, experience of inequality or discrimination, or quality of air, education, housing, or work conditions\textsuperscript{45}) may be much more important than the quality of care in determining mortality. Also, it is recognised that the effectiveness of interventions demonstrated in randomised controlled trials, which include highly selected study participants, is often diluted in routine clinical practice.\textsuperscript{46}

Perhaps non-incentivised activities are more important in determining mortality in the patient population. It is also possible that practices misreport performance so as to exaggerate the quality of care, although there is little evidence that this is a significant problem.\textsuperscript{47}

The authors found evidence that the QOF was associated with a modest slowing of the increase in emergency admissions for conditions for which care is incentivised by the QOF, and an increase in primary care attendances for people with serious mental illness. Whether the QOF is responsible for these is unclear; many other factors are likely to have influenced admission and attendance rates over the period, including changes in medical technology or access to other services, or national standards for management of long-term conditions. In any case, among interventions to prevent emergency admissions, pay-for-performance is unlikely to be one of the most effective.\textsuperscript{48,49}

It could be argued that some QOF indicators — in palliative care, cancer, SMI, dementia, and rheumatoid arthritis — incentivise multidisciplinary meetings, reviews, and care plans, considered necessary elements of holistic and
integrated care (as set out in recent
guidance from NICE).50 However, to achieve
the indicators, practices are not required
to demonstrate that their activities ensure
that holistic or integrated care has been
delivered.

Implications for research and practice
The authors found no convincing evidence
that the QOF promotes better care and
outcomes for people with long-term
conditions. QOF may also have negative
effects. If practices have achieved maximum
or near maximum points under the scheme
(which is true for most practices), they have
little motivation to improve achievement
further. It is likely that the QOF diverts
practices and professionals from ways of
providing high-quality primary care that is
not QOF-related. Moreover, the QOF does
not incentivise practices to improve care
for patients with the most complex needs
in primary care, because these are more
likely to be excepted from the scheme.51
Raising thresholds for achievement may be
counterproductive — there is evidence that
it leads to increased exception reporting,
raising apparent achievement with no real
increase in the desired activity.52
The Chief Executive of the NHS
announced in October 2016 that the
QOF would be phased out.53 What would
happen to the quality of primary care if
the QOF is completely abolished is not
clear, although it seems unlikely that
standards would drop significantly, because
the activities rewarded in the QOF are
now firmly embedded in practice. There
is some limited evidence to suggest that
performance did not fall following the
withdrawal of certain individual indicators
from the scheme.54 Abolishing the QOF
may also allow practices to prioritise other
activities, which could lead to better care.

The QOF provides a major component
of practice income; if it were abolished,
practices would need to be assured of a
stable income. Losing this is likely to have
detrimental effects on patient care and
further worsen recruitment and retention
in primary care, which is once again in a
precarious position.55

Alternative methods of rewarding good
practice are being considered for new
models of primary care.56 Any replacement
for the QOF needs to consider the evidence
of effectiveness of pay-for-performance in
primary care, and the evidence of what
motivates primary care professionals to
provide high-quality care.57

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the researchers and not necessarily those of
the Department of Health.

Ethical approval
Not applicable.

Provenance
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Competing interests
The authors have declared no competing
interests.

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databases, Ms Linda Jenkins for her help
with downloading and interpreting QOF
reporting data, and Dr Mark Ashworth for
his advice on interpreting the results.

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### Appendix 1. QOF indicators 2016/2017 relating to care of long-term conditions

<table>
<thead>
<tr>
<th>Long-term condition</th>
<th>QOF code</th>
<th>Brief description of indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Asthma</strong></td>
<td>AST001</td>
<td>Register of patients with asthma</td>
</tr>
<tr>
<td></td>
<td>AST002</td>
<td>Percentage of patients with asthma and measures of variability or reversibility recorded</td>
</tr>
<tr>
<td></td>
<td>AST003</td>
<td>Percentage of patients with asthma who have had control assessed</td>
</tr>
<tr>
<td></td>
<td>AST004</td>
<td>Percentage of patients with asthma with record of smoking status</td>
</tr>
<tr>
<td><strong>Atrial fibrillation</strong></td>
<td>AF001</td>
<td>Register of patients with atrial fibrillation</td>
</tr>
<tr>
<td></td>
<td>AF006</td>
<td>Percentage of patients with atrial fibrillation in whom stroke risk has been assessed</td>
</tr>
<tr>
<td></td>
<td>AF007</td>
<td>Anticoagulant therapy in those with atrial fibrillation and high risk of stroke</td>
</tr>
<tr>
<td><strong>Cancer</strong></td>
<td>CAN001</td>
<td>Register of patients with cancer</td>
</tr>
<tr>
<td></td>
<td>CAN003</td>
<td>Percentage of patients with cancer who have been reviewed</td>
</tr>
<tr>
<td><strong>Chronic kidney disease (CKD)</strong></td>
<td>CKD001</td>
<td>Register of patients with chronic kidney disease</td>
</tr>
<tr>
<td><strong>Chronic obstructive pulmonary disease (COPD)</strong></td>
<td>COPD001</td>
<td>Register of patients with COPD</td>
</tr>
<tr>
<td></td>
<td>COPD002</td>
<td>Percentage of patients with COPD with diagnosis confirmed by post-bronchodilator spirometry</td>
</tr>
<tr>
<td></td>
<td>COPD003</td>
<td>Percentage of patients with COPD who have had a review with assessment of breathlessness</td>
</tr>
<tr>
<td></td>
<td>COPD004</td>
<td>Percentage of patients with COPD with a record of forced expiratory volume in 1 second (FEV1)</td>
</tr>
<tr>
<td></td>
<td>COPD005</td>
<td>Percentage of patients with severe COPD with record of oxygen saturation</td>
</tr>
<tr>
<td></td>
<td>COPD007</td>
<td>Percentage of patients with COPD who have had influenza immunisation</td>
</tr>
<tr>
<td><strong>Coronary heart disease (CHD)</strong></td>
<td>CHD001</td>
<td>Register of patients with CHD</td>
</tr>
<tr>
<td></td>
<td>CHD002</td>
<td>Percentage of patients with CHD with blood pressure 150/90 mmHg or less</td>
</tr>
<tr>
<td></td>
<td>CHD005</td>
<td>Percentage of patients with CHD taking aspirin, an alternative antiplatelet therapy, or an anticoagulant</td>
</tr>
<tr>
<td></td>
<td>CHD007</td>
<td>Percentage of patients with CHD who have had influenza immunisation</td>
</tr>
<tr>
<td><strong>Dementia</strong></td>
<td>DEM001</td>
<td>Register of patients with dementia</td>
</tr>
<tr>
<td></td>
<td>DEM004</td>
<td>Percentage of patients with dementia whose care plan has been reviewed face-to-face</td>
</tr>
<tr>
<td></td>
<td>DEM005</td>
<td>Percentage of patients with a new diagnosis of dementia with record of tests to exclude reversible cause</td>
</tr>
<tr>
<td><strong>Depression</strong></td>
<td>DEP003</td>
<td>Percentage of patients with new diagnosis of depression with review soon after diagnosis</td>
</tr>
<tr>
<td><strong>Diabetes mellitus</strong></td>
<td>DM002</td>
<td>Percentage of patients with diabetes with blood pressure 150/90 mmHg or less</td>
</tr>
<tr>
<td></td>
<td>DM003</td>
<td>Percentage of patients with diabetes with blood pressure 140/80 mmHg or less</td>
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<tr>
<td></td>
<td>DM004</td>
<td>Percentage of patients with diabetes with total cholesterol 5 mmol/l or less</td>
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<tr>
<td></td>
<td>DM006</td>
<td>Percentage of patients with diabetes and nephropathy taking angiotensin converting enzyme inhibitors or angiotensin receptor blockers (ACEIs or ARBs)</td>
</tr>
<tr>
<td></td>
<td>DM007</td>
<td>Percentage of patients with diabetes with glycated haemoglobin 59 mmol/mol or less</td>
</tr>
<tr>
<td></td>
<td>DM008</td>
<td>Percentage of patients with diabetes with glycated haemoglobin 64 mmol/mol or less</td>
</tr>
<tr>
<td></td>
<td>DM009</td>
<td>Percentage of patients with diabetes with glycated haemoglobin 75 mmol/mol or less</td>
</tr>
<tr>
<td></td>
<td>DM012</td>
<td>Percentage of QOF patients with diabetes with a record of a foot examination and foot risk classification</td>
</tr>
<tr>
<td></td>
<td>DM014</td>
<td>Patients newly diagnosed with diabetes referred to a structured education programme</td>
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<tr>
<td></td>
<td>DM017</td>
<td>Register of patients with diabetes</td>
</tr>
<tr>
<td></td>
<td>DM018</td>
<td>Percentage of patients with diabetes who have had influenza immunisation</td>
</tr>
<tr>
<td><strong>Epilepsy</strong></td>
<td>EP001</td>
<td>Register of patients with epilepsy</td>
</tr>
<tr>
<td><strong>Heart failure</strong></td>
<td>HF001</td>
<td>Register of patients with heart failure</td>
</tr>
<tr>
<td></td>
<td>HF002</td>
<td>Percentage of patients with heart failure confirmed by an echocardiogram or by specialist assessment</td>
</tr>
<tr>
<td></td>
<td>HF003</td>
<td>Percentage of patients with heart failure taking ACEIs or ARBs</td>
</tr>
<tr>
<td></td>
<td>HF004</td>
<td>Percentage of patients with heart failure taking ACEIs or ARBs plus beta-blocker</td>
</tr>
<tr>
<td><strong>Hypertension</strong></td>
<td>HYP001</td>
<td>Register of patients with hypertension</td>
</tr>
<tr>
<td></td>
<td>HYP006</td>
<td>Percentage of patients with hypertension with blood pressure of 150/90 mmHg or less</td>
</tr>
<tr>
<td></td>
<td>CVD-PP001</td>
<td>Percentage of patients with hypertension and high cardiovascular risk treated with statins</td>
</tr>
<tr>
<td><strong>Learning disability</strong></td>
<td>LD003</td>
<td>Register of patients with learning disability</td>
</tr>
<tr>
<td><strong>Mental health</strong></td>
<td>MH001</td>
<td>Register of patients with serious mental health problems</td>
</tr>
<tr>
<td></td>
<td>MH002</td>
<td>Percentage of patients with serious mental health problems with comprehensive care plan</td>
</tr>
<tr>
<td></td>
<td>MH003</td>
<td>Percentage of patients with serious mental health problems with record of blood pressure</td>
</tr>
<tr>
<td></td>
<td>MH007</td>
<td>Percentage of patients with serious mental health problems with record of alcohol consumption</td>
</tr>
<tr>
<td></td>
<td>MH008</td>
<td>Percentage of women with serious mental health problems with cervical screening test performed</td>
</tr>
<tr>
<td></td>
<td>MH009</td>
<td>Percentage of patients on lithium therapy having renal and thyroid function monitored</td>
</tr>
<tr>
<td></td>
<td>MH010</td>
<td>Percentage of patients on lithium therapy with lithium levels in therapeutic range</td>
</tr>
</tbody>
</table>

*continued*
## Appendix 1 continued. QOF indicators 2016/2017 relating to care of long-term conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Osteoporosis</td>
<td>OST002</td>
<td>Percentage of patients 50–74 with confirmed osteoporosis taking bone-sparing agent</td>
</tr>
<tr>
<td></td>
<td>OST004</td>
<td>Register of patients with osteoporosis</td>
</tr>
<tr>
<td></td>
<td>OST005</td>
<td>Percentage of patients aged &gt;75 with osteoporosis taking bone-sparing agent</td>
</tr>
<tr>
<td>People with palliative care needs</td>
<td>PC001</td>
<td>Register of patients in need of palliative care/support</td>
</tr>
<tr>
<td></td>
<td>PC002</td>
<td>Regular multidisciplinary case review meetings for people receiving palliative care</td>
</tr>
<tr>
<td>Peripheral arterial disease</td>
<td>PAD001</td>
<td>Register of patients with peripheral arterial disease</td>
</tr>
<tr>
<td></td>
<td>PAD002</td>
<td>Percentage of patients with peripheral arterial disease with blood pressure 150/90 mmHg or less</td>
</tr>
<tr>
<td></td>
<td>PAD004</td>
<td>Percentage of patients with peripheral arterial disease taking aspirin or an alternative antiplatelet</td>
</tr>
<tr>
<td>Rheumatoid arthritis</td>
<td>RA001</td>
<td>Register of patients with rheumatoid arthritis</td>
</tr>
<tr>
<td></td>
<td>RA002</td>
<td>Percentage of patients with rheumatoid arthritis who have had a face-to-face review</td>
</tr>
<tr>
<td>Stroke or transient ischaemic attack (STIA)</td>
<td>STIA001</td>
<td>Register of patients with STIA</td>
</tr>
<tr>
<td></td>
<td>STIA003</td>
<td>Percentage of patients with STIA with blood pressure 150/90 mmHg or less</td>
</tr>
<tr>
<td></td>
<td>STIA007</td>
<td>Percentage of patients with non–haemorrhagic stroke or TIA taking antiplatelet agent, or anticoagulant</td>
</tr>
<tr>
<td></td>
<td>STIA008</td>
<td>Percentage of patients with STIA referred for further investigation</td>
</tr>
<tr>
<td></td>
<td>STIA009</td>
<td>Percentage of patients with STIA who have had influenza immunisation</td>
</tr>
<tr>
<td>Several long-term conditions</td>
<td>SMOK002</td>
<td>Percentage of patients with long-term conditions with record of smoking status</td>
</tr>
<tr>
<td></td>
<td>SMOK005</td>
<td>Percentage of smokers with long-term conditions offered smoking cessation support</td>
</tr>
</tbody>
</table>

QOF = Quality and Outcomes Framework.