PURE HEALTH & WELLBEING

Cardiovascular Disease (CVD) and Diabetes – Key QOF Indicators

Following the release of the DES 25/26, Cardiovascular diseases (CVD) and Diabetes now account for 76% of clinical QOF points within the clinical domain, with thresholds significantly raised and target levels established for Blood Pressure, Cholesterol, and HBA1C. This document breaks down the new QOF indicators to help practices meet their CVD and Diabetes QOF targets.

CVD-Related Indicators

Atrial Fibrillation

AF006 – 12 points
AF008 – 12 points
Subtotal: 24 points

Coronary Heart Disease (CHD)

CHD005 – 7 points
CHD015 – 33 points
CHD016 – 14 points
Subtotal: 54 points

Cholesterol Control / Lipid Management

CHOL003 – 38 points
CHOL004 – 44 points
Subtotal: 82 points

Heart Failure

HF008 – 6 points
HF003 – 6 points
HF006 – 6 points
HF007 – 7 points
Subtotal: 25 points

Hypertension

HYP008 – 38 points
HYP009 – 14 points
Subtotal: 52 points

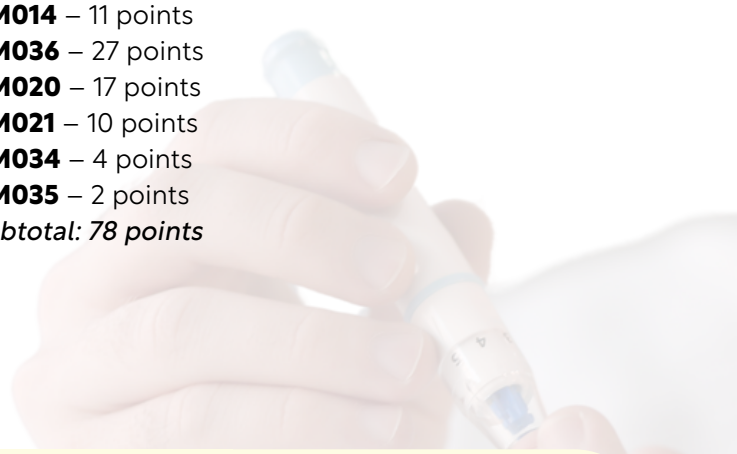
Stroke / TIA

STIA007 – 4 points
STIA014 – 8 points
STIA015 – 6 points
Subtotal: 18 points

Diabetes / Metabolic Health Indicators

Diabetes Mellitus

DM006 – 3 points
DM012 – 4 points
DM014 – 11 points
DM036 – 27 points
DM020 – 17 points
DM021 – 10 points
DM034 – 4 points
DM035 – 2 points
Subtotal: 78 points



Total QOF Points

- CVD-Related Total: 24 + 54 + 82 + 25 + 52 + 18 = **255 points**
- Diabetes Total: **78 points**
- Overall Total (CVD + Diabetes/Metabolic Health): **333 QOF Points out of a total of 437** (76%)
- Approx income per practice **£225.49 x 333 = £75,088 (out of a total of £98,539)**

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Cardiovascular Disease (CVD) – New Targets

Atrial Fibrillation (AF)

AF006 – CHA_2DS_2-VASc score recorded annually for AF patients (unless score ≥2 already): *12 points | Threshold: 40–90%*
AF008 – Patients with CHA_2DS_2-VASc ≥2 prescribed a DOAC or alternative anticoagulant: *12 points | Threshold: 70–95%*

Coronary Heart Disease (CHD)

CHD005 – Aspirin/antiplatelet/anticoagulant prescribed: *7 points | Threshold: 56–96%*
CHD015 – BP ≤140/90 mmHg in CHD patients aged ≤79: *33 points | Threshold: 40–90%*
CHD016 – BP ≤150/90 mmHg in CHD patients aged ≥80: *14 points | Threshold: 46–90%*

Cholesterol / Lipid Management

CHOL003 – Statin or lipid-lowering therapy for CVD/high-risk patients: *38 points | Threshold: 70–95%*
CHOL004 – LDL ≤2.0 mmol/L or non-HDL ≤2.6 mmol/L in CHD/PAD/TIA patients: *44 points | Threshold: 20–50%*

Heart Failure (HF)

HF008 – Diagnosis confirmed via echo or specialist: *6 points | Threshold: 50–90%*
HF003 – On ACE inhibitor or ARB: *6 points | Threshold: 60–92%*
HF006 – On a beta-blocker for heart failure: *6 points | Threshold: 60–92%*
HF007 – Annual review with functional and medication assessment: *7 points | Threshold: 50–90%*

Hypertension

HYP008 – BP ≤140/90 mmHg for patients aged ≤79: *38 points | Threshold: 40–85%*
HYP009 – BP ≤150/90 mmHg for patients aged ≥80: *14 points | Threshold: 40–85%*

Stroke / TIA

STIA007 – Antiplatelet or anticoagulant use: *4 points | Threshold: 57–97%*
STIA014 – BP ≤140/90 mmHg for stroke/TIA patients aged ≤79: *8 points | Threshold: 40–90%*
STIA015 – BP ≤150/90 mmHg for stroke/TIA patients aged ≥80: *6 points | Threshold: 46–90%*

Diabetes – New Targets

Diabetes Mellitus (DM)

DM006 – Nephropathy/microalbuminuria treated with ACE-I/ARB: *3 points | Threshold: 57–97%*
DM012 – Annual foot exam with risk classification: *4 points | Threshold: 50–90%*
DM014 – Referral to structured education within 9 months of diagnosis: *11 points | Threshold: 40–90%*
DM036 – BP ≤140/90 mmHg for patients ≤79 without frailty: *27 points | Threshold: 38–90%*
DM020 – HbA1c ≤58 mmol/mol for patients without frailty: *17 points | Threshold: 35–75%*
DM021 – HbA1c ≤75 mmol/mol for patients with moderate/severe frailty: *10 points | Threshold: 52–92%*
DM034 – Statin for diabetes patients aged ≥40 with no CVD and no frailty (unless low risk): *4 points | Threshold: 50–90%*
DM035 – Statin for diabetes patients with a history of CVD: *2 points | Threshold: 50–90%*

Key Implications for PCNs

- **CVD + Diabetes QOF now accounts for the majority of clinical QOF points**, especially with high-value indicators like blood pressure and statin prescribing.
- **Raising thresholds (often up to 90%) means PCNs must actively manage long-term conditions**, not just record them.
- **Health and Wellbeing Coaches, pharmacists, and social prescribing link workers** are ideally placed to support medication adherence, behaviour change, and structured education.
- **Maximising QOF income now demands integrated, preventative models of care.**