NICE Indicator Programme

BMA Consultation on new NICE indicators

# Please return this form to [info.lmcqueries@bma.org.uk](mailto:info.lmcqueries@bma.org.uk) by 5pm Friday 14 October 2022.

This consultation presents new indicators on:

* Physical health monitoring for people with serious mental illness
* Anticoagulation for people with atrial fibrillation
* Lipid modification: secondary prevention
* Blood pressure control and pharmacological management for people with chronic kidney disease

General practice indicators may be assessed as suitable for inclusion in the Quality and Outcomes Framework (QOF). QOF forms part of the GMS contract. The content of QOF is determined by negotiations between NHS England and the BMA’s General Practitioners Committee.

There are four generic questions associated with each indicator, as well as some indicator-specific questions. You can also enter your own general comments.

# Mental health: physical health checks

IND2022-127: Percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who, in the preceding 12 months, received all six elements of physical health checks for people with severe mental illness.

## Indicator type

General practice indicator suitable for use in the QOF.

## Rationale

The aim of the annual checks is to identify and address risk factors linked to premature death. People with severe mental illness (SMI) are at a greater risk of poor physical health and die on average 15 to 20 years earlier than the general population. Major causes of death in people with SMI include cardiovascular disease, respiratory disease, diabetes and hypertension ([PHE 2018](https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities/severe-mental-illness-and-physical-health-inequalities-briefing)). Individual indicators on the provision of these health checks are already part of the NICE indicator menu and included in the QOF.

Current practice data show that in many cases people with SMI do not receive all six elements of the physical health check ([NHS England 2022](https://www.england.nhs.uk/statistics/statistical-work-areas/serious-mental-illness-smi/)). It is expected that this indicator, incorporating all six elements of the physical health check, will increase the number of people with SMI who receive these checks annually.

## Source guidance

[NICE’s guideline on psychosis and schizophrenia in adults: prevention and management](https://www.nice.org.uk/guidance/cg178) (2014) recommendations 1.1.3.3, 1.1.3.6, 1.3.3.4, 1.3.6.1, 1.5.3.2 and 1.5.3.3.

[NICE’s guideline on bipolar disorder](https://www.nice.org.uk/guidance/cg185) (2014, updated 2020) recommendations 1.2.4, 1.2.12, 1.3.4 and 1.9.4.

[NICE’s guideline on alcohol-use disorders: prevention](https://www.nice.org.uk/guidance/ph24) (2010) recommendations 6, 7 and 9.

## Specification

Numerator: the number in the denominator who, in the preceding 12 months, received all six elements of physical health checks for people with severe mental illness.

Denominator: the total number of registered patients with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses.

Definition: The six elements of physical health checks are:

* a record of blood pressure.
* a record of BMI.
* a record of alcohol consumption.
* a record of a lipid profile.
* a record of blood glucose or HbA1c.
* a record of smoking status.

Exclusions: Patients in remission

At the patient level, personalised care adjustments (PCAs) against each health check should be considered to account for situations where the patient declines, does not respond to invite or if the physical health check is not appropriate.

The denominator will include:

* Patients who have received all 6 physical health checks
* Patients who have not received all 6 checks, and for at least one of these checks there is no personalised care adjustment recorded.

Patients who have received less than 6 health checks but whose total number of health checks plus PCAs equals exactly 6 will be rejected from the denominator.

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| Feedback - Mental health: physical health checks | | |
| 1 | Do you think there are any barriers to implementing the care described by this indicator? |  |
| 2 | Do you think there are potential unintended consequences to implementing/ using this indicator? |  |
| 3 | Do you think there is potential for differential impact (in respect of age, disability, gender and gender reassignment, pregnancy and maternity, race, religion or belief, and sexual orientation)? If so, please state whether this is adverse or positive and for which group. |  |
| 4 | If you think this indicator may have an adverse impact in different groups in the community, can you suggest how it might be delivered differently to different groups to reduce health inequalities? |  |
| Other comments |  | |

# Atrial fibrillation: anticoagulation

IND2022-131: Percentage of patients with atrial fibrillation and a last recorded CHA2DS2- VASc score of 2 or more who are currently prescribed a direct-acting oral anticoagulant (DOAC), or where a DOAC is declined or clinically unsuitable, a Vitamin K antagonist.

## Indicator type

General practice indicator suitable for use in the QOF.

This indicator is based on existing indicator CVD-05 in the [Investment and Impact Fund 2022/23](https://www.england.nhs.uk/wp-content/uploads/2022/03/B1357-investment-and-impact-fund-2022-23-updated-guidance-march-2022.pdf).

## Rationale

Anticoagulation in patients with atrial fibrillation (AF) can help prevent stroke. Evidence from an analysis of several studies shows that DOACs are more effective than Vitamin K antagonists for a number of outcomes and should be used as a first line treatment [(NICE, NG196](https://www.nice.org.uk/guidance/ng196/chapter/Recommendations#stroke-prevention)).

For patients already established and stable on a vitamin K antagonist, the benefits of changing to a DOAC need to be discussed with the patient. Therefore, the risks and benefits of changing medication, the person's time in therapeutic range and the person's preferences should be explored at their next routine appointment [(NICE, NG196](https://www.nice.org.uk/guidance/ng196/chapter/Recommendations#stroke-prevention)).

This indicator aims to promote the use of DOACs over vitamin K antagonists unless DOACs are unsuitable or declined by the patient.

## Source guidance

[NICE’s guideline on atrial fibrillation](https://www.nice.org.uk/guidance/ng196) (2021) recommendations 1.6.3, 1.6.4 and 1.6.5.

## Specification

Numerator: the number in the denominator who are currently prescribed a DOAC, or where a DOAC is declined or clinically unsuitable, a Vitamin K antagonist.

Denominator: the number of patients with atrial fibrillation and a last recorded CHA2DS2- VASc score of 2 or more.

Definition: Current treatment is defined as a prescription in the last 6 months of the reporting period.

Exclusions: People with resolved atrial fibrillation.

## Using established guidance for existing IIF Indicator CVD-05 this indicator has multiple success criteria that are evaluated sequentially. A personalised care adjustment (PCA) for the first success criterion (DOAC prescribing) moves the patient into the pool for evaluation against the second criterion (Vitamin K antagonist prescribing), rather than removing them from the denominator altogether.

## PCAs for success criterion 1 (moves the patient to evaluation under success criterion 2):

* DOAC clinically unsuitable (includes recordings of antiphospholipid syndrome).
* ‘DOAC not indicated’ plus last recording of ‘Time in Therapeutic Range’ >= 65% in the six months to the reporting period end date.
* DOAC declined.

## PCAs for success criterion 2:

* Vitamin K antagonist / Warfarin clinically unsuitable.
* Vitamin K antagonist / Warfarin declined.

## Possible grounds for exception reporting in the traditional sense (i.e. removal from the denominator altogether, unless a success is registered) are:

* First AF diagnosis in 3 months to reporting period end date
* Oral anticoagulant clinically unsuitable
* Oral anticoagulant declined
* A combination of PCAs applying to success criteria 1 and 2 individually.

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| Feedback - Atrial fibrillation: anticoagulation | | |
| 1 | Do you think there are any barriers to implementing the care described by this indicator? |  |
| 2 | Do you think there are potential unintended consequences to implementing/ using this indicator? |  |
| 3 | Do you think there is potential for differential impact (in respect of age, disability, gender and gender reassignment, pregnancy and maternity, race, religion or belief, and sexual orientation)? If so, please state whether this is adverse or positive and for which group. |  |
| 4 | If you think this indicator may have an adverse impact in different groups in the community, can you suggest how it might be delivered differently to different groups to reduce health inequalities? |  |
| Other comments |  | |

# Lipid modification: secondary prevention

IND2022-133: The percentage of patients with CVD in whom the last recorded non-HDL cholesterol (measured in the preceding 12 months) is less than 3.3 mmol/L.

## Indicator type

General practice indicator suitable for use in the QOF

## Rationale

This indicator aims to drive population level improvements in secondary prevention of cardiovascular disease. It uses a non-HDL cholesterol level of 3.3 mmol/L as a population level marker of lipid management for people with cardiovascular disease.

## Source guidance

[NICE’s guideline on cardiovascular disease](https://www.nice.org.uk/guidance/cg181) recommends lifestyle modification and lipid lowering therapies for the secondary prevention of cardiovascular disease but does not include an absolute target for non-HDL cholesterol levels. The draft indicator has been developed specifically for use in the QOF following stakeholder feedback that a pragmatic means of monitoring lipid management that does not rely on baseline readings or calculating a 40% reduction in non-HDL would be useful.

Baseline cholesterol readings are not always available, and NICE have heard that the current national data extraction system for QOF (GPES) cannot calculate patient level percentage reductions in non-HDL.

A non-HDL level of less than 3.3 mmol/L has been chosen as a starting point for incremental improvements at a population level. As such, it is higher than some treatment goals included in the European Society of Cardiology (ESC) and Joint British Societies (JBS) lipid management guidelines. It draws on current practice data from [CVDPrevent](https://www.cvdprevent.nhs.uk/data-explorer?period=4&area=1&indicator=30) and guidance from NICE’s technology appraisal programme. CVDPrevent data published in Sept 2022 reports that for patients aged 18 and over with CVD, only 23.7% had non-HDL less than 2.5mmol/l or LDL-c less than 1.8mmol/l using measurements recorded in the preceding 12 months.

A non-HDL cholesterol level of less than 3.3 mmol/L should not be considered as a treatment target for individual patients, and it **does not** update or replace current NICE guidance. This indicator, if progressed, will be reviewed when updated NICE guidance is available.

**Specification**

Numerator: the number in the denominator in whom the last recorded non-HDL cholesterol (measured in the preceding 12 months) is less than 3.3 mmol/L.

Denominator: the number of patients with CVD.

Definition: CVD is defined as angina, previous myocardial infarction, revascularisations, ischaemic stroke or TIA or symptomatic peripheral arterial disease. Existing QOF registers could be used for coronary heart disease (CHD001), stroke or TIA (STIA001 excluding haemorrhagic stroke) and symptomatic peripheral arterial disease (PAD001).

Exclusions: Patients with a diagnosis of familial hypercholesterolaemia.

Personalised care adjustments should be considered to account for situations where the patient declines, does not respond to invite or if lipid management is not appropriate for the individual.

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| Feedback - Lipid modification: secondary prevention | | |
| 1 | Do you think there are any barriers to implementing the care described by this indicator? |  |
| 2 | Do you think there are potential unintended consequences to implementing/ using this indicator? |  |
| 3 | Do you think there is potential for differential impact (in respect of age, disability, gender and gender reassignment, pregnancy and maternity, race, religion or belief, and sexual orientation)? If so, please state whether this is adverse or positive and for which group. |  |
| 4 | If you think this indicator may have an adverse impact in different groups in the community, can you suggest how it might be delivered differently to different groups to reduce health inequalities? |  |
| 5 | NICE proposed non-HDL level of less than 3.3 mmol/L across a general practice population. Do you agree with using this to drive population level improvements in cholesterol management? If not, what level should be used and why? |  |
| 6 | Should the indicator include an LDL component alongside non-HDL? For example:  *‘The percentage of patients with CVD in whom the last recorded non-HDL cholesterol (measured in the preceding 12 months) is less than 3.3 mmol/L, or where this is missing a recording of LDL cholesterol in the preceding 12 months that is less than 2.6 mmol/L’* |  |
| 7 | Should patients with a diagnosis of familial hypercholesterolaemia be excluded? |  |
| 8 | Would a similar indicator focussed on people with chronic kidney disease be useful and should it use the same level of non-HDL cholesterol? |  |
| Other comments |  | |

# CKD: ARBs and ACE inhibitors

IND2022-136: The percentage of patients on the CKD register and with an albumin to creatinine ratio (ACR) of 70 mg/mmol or more, without diabetes, who are currently treated with an ARB or an ACE inhibitor.

## Indicator type

General practice indicator suitable for use in the QOF

## Rationale

Treatment with renin-angiotensin system antagonists such as ACE inhibitors and angiotensin II receptor blockers (ARBs) can prevent or delay the progression of CKD, reduce or prevent the development of complications and reduce the risk of cardiovascular disease.

## Source guidance

[NICE’s guideline on chronic kidney disease](https://www.nice.org.uk/guidance/ng203) (2021) recommendation 1.6.9.

## Specification

Numerator: The number of patients in the denominator who are currently treated with an ARB or an ACE inhibitor.

Denominator: The number of patients on the CKD register and with an ACR of 70 mg/mmol or more, without diabetes.

Definitions:

* Current treatment is defined as a prescription in the last 6 months of the reporting period.
* The CKD register includes patients aged 18 and over with CKD stages G3a to G5.
* The last recorded reading of ACR should be used for inclusion in the denominator.

Exclusions: People with diabetes have been excluded from the indicator. People with diabetes and with a diagnosis of nephropathy or microalbuminuria are included in NICE menu indicator NM95 on treatment with an ACE inhibitor or ARB.

Personalised care adjustments or exception reporting should be considered to account for situations where the patient declines, does not respond to invite or if treatment is inappropriate.

# CKD: blood pressure (ACR 70 or more)

IND2022-137: The percentage of patients on the CKD register and with an albumin to creatinine ratio (ACR) of 70 mg/mmol or more, without moderate or severe frailty, in whom the last blood pressure reading (measured in the preceding 12 months) is less than 125/75 mmHg if using ambulatory or home monitoring, or less than 130/80 mmHg if monitored in clinic.

## Indicator type

General practice indicator suitable for use in the QOF

## Rationale

Chronic kidney disease (CKD) is a long-term condition characterised by abnormal function or structure (or both). Optimal blood pressure control can slow progression of CKD and reduce the risk of cardiovascular disease. A focus on people without moderate or severe frailty allows for an individualised management approach that adjusts care according to frailty status**.**

## Source guidance

[NICE’s guideline on chronic kidney disease](https://www.nice.org.uk/guidance/ng203) (2021) recommendation 1.6.2.

[NICE’s guideline on hypertension in adults](https://www.nice.org.uk/guidance/ng136) (2019, last updated 2022) recommendations 1.4.10, 1.4.18, 1.4.20 and 1.4.22.

## Specification

Numerator: The number of patients in the denominator in whom the last blood pressure reading (measured in the preceding 12 months) is less than 125/75 mmHg if using ambulatory or home monitoring, or less than 130/80 mmHg if monitored in clinic.

Denominator: The number of patients on the CKD register and with an ACR of 70 mg/mmol or more, without moderate or severe frailty.

Definitions:

* The CKD register includes patients aged 18 and over with CKD stages G3a to G5.
* The last recorded reading of ACR should be used for inclusion in the denominator.

Personalised care adjustments or exception reporting should be considered to account for situations where the patient declines, does not respond to invite or if the blood pressure target is inappropriate.

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| Feedback – Chronic Kidney Disease: ARBs and ACE inhibitors | | |
| 1 | Do you think there are any barriers to implementing the care described by these indicators? |  |
| 2 | Do you think there are potential unintended consequences to implementing/ using these indicators? |  |
| 3 | Do you think there is potential for differential impact (in respect of age, disability, gender and gender reassignment, pregnancy and maternity, race, religion or belief, and sexual orientation)? If so, please state whether this is adverse or positive and for which group. |  |
| 4 | If you think these indicators may have an adverse impact in different groups in the community, can you suggest how it might be delivered differently to different groups to reduce health inequalities? |  |
| 5 | Is it achievable and acceptable to use tighter targets for ambulatory or home monitoring of blood pressure in this population? |  |
| Other comments |  | |