NICE National Institute for Health and Care Excellence

Consultation on potential new indicators for the 2015/16 Quality and Outcomes Framework (QOF)

Consultation dates: 6th January to 3rd February 2014

This document outlines the 10 indicators being consulted on and the questions to consider. A brief rationale and topic overview is included for each indicator (appendix A) and the consultee comments proforma (appendix B).

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Background

As part of the indicator development process for the Quality and Outcomes Framework (QOF), stakeholders have the opportunity to comment on potential new indicators for the NICE QOF menu. We encourage stakeholders from all participating countries to comment on the 10 potential new indicators.

The consultation dates are 6th January to 3rd February 2014. A brief rationale and topic overview for each indicator is provided in appendix A. The consultee comments proforma is provided in appendix B.

These are not the final indicators for the NICE QOF menu. The development process includes both piloting and consultation on indicators. Indicators are subject to change following consideration of the results of piloting and consultation. Comments received during the consultation will be considered by the QOF Advisory Committee in June 2014, along with the results of the piloting of these indicators across a representative sample of general practices. The Committee will then recommend which of these indicators should be considered for inclusion in the NICE menu for consideration for the 2015/16 QOF.

Negotiations between NHS Employers, NHS England, UK Health Departments and the General Practitioners Committee on behalf of the British Medical Association, will decide which indicators are eventually adopted into the 2015/16 QOF.

Indicators for consultation

Indicator clinical area	Indicators in development
Diabetes	1. The percentage of patients with diabetes who have had the following care processes performed in the preceding 12 months: • BMI measurement • BP measurement • HbA1c measurement • Cholesterol measurement • Record of smoking status • Foot examination • Albumin: creatinine ratio • Serum creatinine measurement
Hypertension	2. The percentage of patients with a new diagnosis of hypertension in the preceding 1st April to 31st March who have a record of urinary albumin: creatinine ratio test in the three months before or after the date of entry to the hypertension register.
	3. The percentage of patients with a new diagnosis of hypertension in the preceding 1st April to 31st March who have a record of a test for haematuria in the three months before or after the date of entry to the hypertension register.
	4. The percentage of patients with a new diagnosis of hypertension in the preceding 1st April to 31st March who have a record of a 12 lead ECG performed in the three months before or after the date of entry to the hypertension register.
	5. The percentage of patients with a new diagnosis of hypertension in the preceding 1st April to 31st March who have been screened for hazardous or harmful alcohol consumption using a validated tool in the three months before or after the date of entry on the hypertension register.
	6. The percentage of patients with a new diagnosis of hypertension in the preceding 1st April to 31st March who screen positive for hazardous or harmful alcohol consumption who have been given personalised feedback on their AUDIT score and a patient information leaflet about their level of alcohol related risk or harm within three months of the AUDIT score being recorded.
Polypharmacy	7. The percentage of patients aged 65 years and over who are prescribed 10 or more medications that have had a face to face medication review in the preceding 12 months.

Serious mental illness	8. The percentage of women with schizophrenia, bipolar affective disorder or other psychoses under the age of 45 years who have been given information and advice about pregnancy, conception or contraception tailored to their pregnancy and contraceptive intentions recorded in the preceding 12 months.
	9. The percentage of women with schizophrenia, bipolar affective disorder or other psychoses aged 45 years or less who have been prescribed psychotropic medication in the preceding 12 months who have been advised of the risks of these medications during pregnancy in the preceding 12 months.
Chronic obstructive pulmonary disease	10. The percentage of patients with COPD recorded as having an exacerbation in the preceding 12 months who have been given a course of antibiotics and corticosteroids (rescue pack) as part of a personalised future exacerbation self-management strategy in the preceding 12 months.

There are 10 potential new QOF indicators across 5 areas that are currently being consulted on in this document.

Consultation process

Questions to consider in the consultation

Stakeholders are welcomed to submit comments based on the following set of questions:

1. Do you think there are any barriers to the implementation of the care described by any of these indicators?

2. Do you think there are potential unintended consequences to the implementation of any of these indicators?

3. Do you think there is potential for differential impact (in respect of age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation), if so please state whether this is adverse or positive and for which group?

4. If you think any of these indicators may have an adverse impact in different groups in the community, can you suggest any guidance on adaptation to the delivery of the indicator to different groups which might reduce health inequalities?

In addition to the above questions, stakeholders are invited to comment on the following indicator specific questions:

5. Indicator 1: Retinal screening is not currently included within this composite indicator as it was considered to be outside the control of GPs. Do stakeholders consider it appropriate to include retinal screening in this indicator?

6. Indicator 4: The QOF Advisory Committee recommended that indicators to assess target organ damage focus on tests used in primary care for renal damage and electrocardiographs. Do stakeholders consider the indicators in piloting will provide an adequate assessment of target organ damage?

7. Indicator 6: From a patient perspective do stakeholders consider screening for hazardous or harmful alcohol consumption in people with a new diagnosis of

hypertension and where necessary, subsequent feedback and information appropriate?

8. Indicators 2 – 6: Which of these indicators, relating to hypertension, do stakeholders feel are the highest priority for the QOF?

9. Indicator 7: The age range for this indicator is under review. Do stakeholders feel that age 65 years and over is an appropriate age range for this indicator? If no, please suggest an alternative age range that should be applied to the indicator.

10. Indicator 7: The number of drugs prescribed for this indicator is under review. Do stakeholders feel that 10 drugs is an appropriate number to prompt a medication review? If no, please suggest an alternative number that should be applied to the indicator

11. Indicator 8 & 9: From a patient perspective do stakeholders consider annual provision of pregnancy, conception or contraception advice to people with serious mental illness appropriate?

12. Indicator 8 & 9: Indicators 8 and 9 relate to people with serious mental illness. Which of these indicators do stakeholders feel is the highest priority for the QOF?

How to submit your comments

If you would like to comment on any of the above 10 indicators currently being consulted on please use the comments proforma provided in appendix B (also available on the NICE website) and forward this to Lisa Nicholls at indicators@nice.org.uk by 5pm on Monday 3rd February 2014.

Appendix A: Brief rationale and topic overview for indicators out for consultation

This section provides a brief rationale for each of the topic areas out for consultation; however the rationale is not formal indicator guidance. This will take in to account the results of public consultation and be published when the full set of indicators for the NICE menu for the 2015/16 QOF has been published.

Indicator area: Diabetes (care processes)

Indicator

1. The percentage of patients with diabetes who have had the following care processes performed in the preceding 12 months:

    - BMI measurement
    - BP measurement
    - HbA1c measurement
    - Cholesterol measurement
    - Record of smoking status
    - Foot examination
    - Albumin: creatinine ratio
    - Serum creatinine measurement

Evidence Source

NICE clinical guideline 87: Type 2 diabetes: The management of type 2 diabetes (2009):

Recommendation 1.8.1: Measure blood pressure at least annually in a person without previously diagnosed hypertension or renal disease. Offer and reinforce preventive lifestyle advice.

Recommendation 1.3.2: Measure the individual's HbA_{1c} levels at:

- 2–6-monthly intervals (tailored to individual needs) until the blood glucose level is stable on unchanging therapy; use a measurement made at an interval of less than 3 months as a indicator of direction of change, rather than as a new steady state.
- 6-monthly intervals once the blood glucose level and blood glucose-lowering therapy are stable.

Recommendation 1.9.4: Perform a full lipid profile (including high-density lipoprotein [HDL] cholesterol and triglyceride estimations) when assessing cardiovascular risk after diagnosis and annually, and before starting lipid-modifying therapy.

Recommendation 1.12.1: Ask all people with or without detected nephropathy to bring in a first-pass morning urine specimen once a year. In the absence of proteinuria/urinary tract infection (UTI), send this for laboratory estimation of albumin:creatinine ratio. Request a specimen on a subsequent visit if UTI prevents analysis.

Recommendation 1.12.3: Measure serum creatinine and estimate the glomerular filtration rate (using the method-abbreviated modification of diet in renal disease [MDRD] four-variable equation) annually at the time of albumin:creatinine ratio estimation.

NICE clinical guideline 10: Type 2 diabetes: prevention and management of foot problems:

Recommendation 1.1.2.1: Regular (at least annual) visual inspection of patients' feet, assessment of foot sensation, and palpation of foot pulses by trained personnel is important for the detection of risk factors for ulceration

NICE clinical guideline 15: Type 1 diabetes: Diagnosis and management of type 1 diabetes in children, young people and adults (2004):

Recommendation 1.10.1.1: Arterial risk factors should be assessed annually, and the assessment should include:

- albumin excretion rate
- smoking
- blood glucose control
- blood pressure
- full lipid profile (including HDL and LDL cholesterol and triglycerides)
- age
- family history of arterial disease
- abdominal adiposity.

Recommendation 1.11.2.1: All adults with type 1 diabetes with or without detected nephropathy should be asked to bring in a first-pass morning urine specimen once a year. This should be sent for estimation of albumin:creatinine ratio. Estimation of urine albumin concentration alone is a poor alternative. Serum creatinine should be measured at the same time.

Recommendation 1.11.3.1: Structured foot surveillance should be at 1-year intervals, and should include educational assessment and education input commensurate with the assessed risk.

Brief rationale

The proposed indicator is a composite indicator where a specified set of tests are all required to be carried out to be successful against the indicator: failure to carry out one of the tests is a failure against the entire indicator (unless where unfeasible or clinically inappropriate). An advantage of composite measures is that they can identify opportunities for improvement even when performance on individual measures is generally high. Retinal screening is excluded from this proposed screening as it was considered to be beyond the control of the General Practitioner.

Topic overview

Diabetes is a chronic metabolic disorder caused by defects in insulin secretion and action. There are two major types of diabetes. Type 1 diabetes occurs because the insulin-producing cells of the pancreas have been destroyed by the body's immune system and typically develops in children and young adults. Type 2 diabetes is more commonly diagnosed in adults over the age of 40 years, but is also increasing in young people. In this condition, insulin is produced but is insufficient for the body's needs. There is also a degree of insulin resistance, where the cells in the body are not able to respond to the insulin that is produced. Type 2 diabetes accounts for around 90% of all diabetes in adults.

People with Type 2 diabetes have a life expectancy that is reduced by up to 10 years and are at increased cardiovascular risk. Adults with Type 1 and Type 2 diabetes have their condition managed in primary care, however, it is common for adults with Type 1 diabetes to experience related complications requiring hospital admission. The referral of people with diabetes into secondary care as a result of complications of diabetes or for urological or other specialist services such as counseling or management of stress, anxiety and depression carry a significant resource impact on the NHS. The risk of complications associated with diabetes may be reduced by carrying out each of the 9 care processes.

Further information

Further information on the diabetes can be accessed from the relevant NICE guidance at:

www.nice.org.uk/guidance/CG87

www.nice.org.uk/guidance/CG15

www.nice.org.uk/guidance/CG10

Indicator area: Hypertension (target organ damage)

Indicators

2. The percentage of patients with a new diagnosis of hypertension in the preceding 1st April to 31st March who have a record of urinary albumin: creatinine ratio test in the three months before or after the date of entry to the hypertension register.

3. The percentage of patients with a new diagnosis of hypertension in the preceding 1st April to 31st March who have a record of a test for haematuria in the three months before or after the date of entry to the hypertension register.

4. The percentage of patients with a new diagnosis of hypertension in the preceding 1st April to 31st March who have a record of a 12 lead ECG performed in the three months before or after the date of entry to the hypertension register.

Evidence source

NICE Hypertension Quality Standard (2013):

Statement 2: People with newly diagnosed hypertension receive investigations for target organ damage within 1 month of diagnosis.

NICE clinical guideline 127: Hypertension: Clinical management of primary hypertension in adults (2011):

Recommendation 1.2.6: While waiting for confirmation of a diagnosis of hypertension, carry out investigations for target organ damage (such as left ventricular hypertrophy, chronic kidney disease and hypertensive retinopathy) (see recommendation 1.3.3) and a formal assessment of cardiovascular risk using a cardiovascular risk assessment tool (see recommendation 1.3.2).

Recommendation 1.3.3: For all people with hypertension offer to:

- test for the presence of protein in the urine by sending a urine sample for estimation of the albumin:creatinine ratio and test for haematuria using a reagent strip
- take a blood sample to measure plasma glucose, electrolytes, creatinine, estimated glomerular filtration rate, serum total cholesterol and HDL cholesterol
- examine the fundi for the presence of hypertensive retinopathy
- arrange for a 12-lead electrocardiograph to be performed

Brief rationale for indicator(s)

Assessment of target organ damage can alert the clinician to the effects of possible uncontrolled hypertension, some of which are potentially life threatening and some that may be amenable to potentially curative interventions. It can also support the clinician to decide the appropriate blood pressure threshold at which to consider drug therapy for the treatment of hypertension.

Topic overview

Hypertension is one of the most important preventable causes of premature morbidity and mortality in the UK. Hypertension is a major risk factor for ischaemic and haemorrhagic stroke, myocardial infarction, heart failure, chronic kidney disease, cognitive decline and premature death. Raised blood pressure is also one of the three main modifiable risk factors for cardiovascular disease which account for 80% of all cases of premature coronary heart disease (CHD).

Blood pressure is normally distributed in the population and there is no natural cut-off point above which 'hypertension' definitively exists and below which it does not. The risk associated with increasing blood pressure is continuous, with each 2 mmHg rise in systolic blood pressure associated with a 7% increased risk of mortality from ischaemic heart disease and a 10% increased risk of mortality from stroke.

Untreated hypertension is usually associated with a progressive rise in blood pressure, often culminating in a treatment resistant state due to associated vascular and renal damage.

The clinical management of hypertension is one of the most common interventions in primary care, accounting for approximately £1 billion in drug costs alone in 2006.

Further information

Further information on hypertension can be accessed from the relevant NICE guidance on hypertension from:

http://guidance.nice.org.uk/CG127

Indicator area: Hypertension (case finding and brief intervention for hazardous or harmful alcohol consumption)

Indicators

5. The percentage of patients with a new diagnosis of hypertension in the preceding 1st April to 31st March who have been screened for hazardous or harmful alcohol consumption using a validated tool in the three months before or after the date of entry on the hypertension register.

6. The percentage of patients with a new diagnosis of hypertension in the preceding 1st April to 31st March who screen positive for hazardous or harmful alcohol consumption who have been given personalised feedback on their AUDIT score and a patient information leaflet about their level of alcohol related risk or harm within three months of the AUDIT score being recorded.

Evidence source

NICE public health guidance 24: Alcohol-use disorders - preventing the development of hazardous and harmful drinking (2010):

Recommendation 9 (relevant extracts)[1]:

- NHS professionals should routinely carry out alcohol screening as an integral part of practice. For instance, discussions should take place during new patient registrations, when screening for other conditions and when managing chronic disease or carrying out a medicine review. These discussions should also take place when promoting sexual health, when seeing someone for an antenatal appointment and when treating minor injuries.
- Complete a validated alcohol questionnaire with the adults being screened. Alternatively, if they are competent enough, ask them to fill one in themselves. Use AUDIT to decide whether to offer them a brief intervention (and, if so, what type) or whether to make a referral. If time is limited, use an abbreviated version (such as AUDIT-C, AUDIT-PC, SASQ or FAST). Screening tools should be appropriate to the setting. For instance, in an emergency department FAST or PAT would be most appropriate.

Recommendation 10 (relevant extracts)[1]:

- Offer a session of structured brief advice on alcohol. If this cannot be offered immediately, offer an appointment as soon as possible thereafter.

[1] For the full recommendation see NICE PH24

Brief rationale for indicator(s)

Evidence suggests that excessive drinking (men: more than 21 units/week; women: more than 14 units/week) is associated both with raised blood pressure and a poorer prognosis. Evidence also suggests that interventions to reduce alcohol consumption results in reductions in both systolic and diastolic blood pressure. These potential new QOF indicators aim to test the feasibility of indicators for case finding and brief intervention for hazardous or harmful alcohol consumption.

Topic overview

Alcohol dependence and harmful alcohol use are associated with increased risk of physical and mental health comorbidities including gastrointestinal disorders (in particular liver disease), neurological and cardiovascular disease, depression and anxiety disorders and ultimately, premature death. It is estimated that 24% of people aged between 16 and 65 in England consume alcohol in a way that is potentially or actually harmful to their health or well-being. Depending on the diagnostic criteria used, alcohol dependence affects between 3% and 6% of people. Brief interventions can be effective in reducing drinking in hazardous and harmful drinkers, but people with alcohol dependence and some harmful drinkers will require more specialist alcohol services. Alcohol misuse is also an increasing problem in children and young people, with over 24,000 treated in the NHS for alcohol-related problems in 2008 and 2009. Current practice across the country is varied and access to a range of specialist alcohol services varies as a consequence.

Alcohol dependence and harmful alcohol use are associated with increased risk of physical and mental health comorbidities including gastrointestinal disorders (in particular liver disease), neurological and cardiovascular disease, depression and anxiety disorders and, ultimately, premature death.

Further information

Further information on preventing the development of hazardous and harmful drinking can be accessed from the relevant NICE public health guidance on alcohol use disorders from:

http://guidance.nice.org.uk/PH24

Indicator area: Polypharmacy (medication review)

Indicator

7. The percentage of patients aged 65 years and over who are prescribed 10 or more medications that have had a face to face medication review in the preceding 12 months.

Evidence source

Review of 2012/13 QOF indicator: MEDICINES 11

Brief rationale for indicator(s)

There is evidence to suggest that some people are prescribed excessive medication, resulting in secondary morbidity from unnecessary or inappropriate medicines, drug incompatibility and poor medicines adherence. This is a particular problem for people with co-morbidities that require multiple medications.

This potential new QOF indicator aims to test the feasibility of an indicator around medication reviews for people prescribed 10 or more medications.

Topic overview

Polypharmacy has also been associated with the use of 'high risk' drugs, higher rates of adverse drug events [2], higher rates of prescribing errors [3] and a mix of underuse of indicated drugs and overuse of non-indicated drugs [4].

It is thought that between a third and a half of all medicines prescribed for long term conditions are not taken as recommended. If the prescription is appropriate, then this may represent a loss of benefits to people, the healthcare system and society. The costs are both personal and economic (NICE, 2009).

The vast majority of prescribing is carried out by general practitioners, with over 90% of prescriptions made using GP computer systems with access to patients' electronic health records, and over 70% of prescriptions being repeats which need to be reviewed periodically.

Further information

Further information on medicines adherence can be accessed from the relevant NICE guidance on medicines adherence from:

http://guidance.nice.org.uk/CG76

Indicator area: Serious mental illness (preconception care and advice)

Indicators

8. The percentage of women with schizophrenia, bipolar affective disorder or other psychoses under the age of 45 years who have been given information and advice about pregnancy, conception or contraception tailored to their pregnancy and contraceptive intentions recorded in the preceding 12 months.

9. The percentage of women with schizophrenia, bipolar affective disorder or other psychoses aged 45 years or less who have been prescribed psychotropic medication in the preceding 12 months who have been advised of the risks of these medications during pregnancy in the preceding 12 months.

Evidence source

NICE clinical guideline 38: Bipolar disorder (2006):

Recommendation 1.4.1.2: Contraception and the risks of pregnancy (including the risks of relapse, damage to the fetus, and the risks associated with stopping or changing medication) should be discussed with all women of child-bearing potential, regardless of whether they are planning a pregnancy. They should be encouraged to discuss pregnancy plans with their doctor

SIGN guideline 131: Management of schizophrenia (2013):

Recommendation: All women with childbearing potential who take psychotropic medication should be made aware of the potential effects of the medications in pregnancy. The use of reliable contraceptive methods should be discussed.

NICE clinical guideline 45: Antenatal and postnatal mental health (2007):

Recommendation 1.1.1.4: Healthcare professionals should discuss contraception and the risks of pregnancy (including relapse, risk to the fetus and risks associated with stopping or changing medication) with all women of child-bearing potential who have an existing mental disorder and/or who are taking psychotropic medication. Such women should be encouraged to discuss pregnancy plans with their doctor

Brief rationale for indicator(s)

Women need to be provided with information regarding the importance of contraception, including the option of long-term reversible contraception. It is important that women are aware of the potential for medication to cause adverse obstetric and neonatal outcomes, including teratogenesis. Women who are considering conceiving should discuss the matter with their psychiatrist, in particular

the issue of medication and maintenance treatment for their bipolar disorder. The advice that is given will depend on the individual's history and circumstances.

There is evidence to suggest that that some psychotropic drugs have high teratogenic risks during the first trimester of pregnancy. As many pregnancies may not be confirmed until the pregnancy is advanced, it is important that women of child bearing potential are given information on the risks of psychotropic medication on pregnancy, the risks of untreated illness and appropriate information about contraception.

Topic overview

The two main categories of serious mental illness are schizophrenia and bipolar disorder.

Schizophrenia is a major psychiatric disorder, or cluster of disorders, characterised by psychotic symptoms that alter a person's perception, thoughts and behaviour. It is characterised by 'positive symptoms' such as auditory hallucinations, bizarre delusions, and disrupted speech ('thought disorder') and by 'negative symptoms' such as social withdrawal, demotivation, self neglect, and the appearance of flat affect. Subtle cognitive impairment is also a feature.

Bipolar disorder is a serious mental illness characterised by episodes of depressed mood and episodes of elated mood (mania or hypomania). For many people the predominant experience is of low mood. In its more severe forms, bipolar disorder is associated with significant impairment of personal and social functioning. In terms of classification, in DSM-V a distinction is drawn between bipolar I disorder, in which the patient suffers full-blown manic episodes (most commonly interspersed with episodes of major depression), and bipolar II disorder, in which the patient experiences depressive episodes and less severe manic symptoms, classed as hypomanic episodes (it must be noted that ICD-10 does not include bipolar II disorder).

The 2008 Kings Fund report, Paying the Price; the cost of mental health in England to 2026, estimates that in 2007 the total cost of lost employment relating to schizophrenia was £1.78 billion and £3.57 billion for bipolar disorder and related conditions.

Most people with bipolar disorder are cared for by their primary care practitioner. The treatment and management of bipolar disorder in women who are trying to conceive, and during the antenatal and postnatal periods, is challenging and complex. This is largely because the risks of taking medication during pregnancy are not always well understood and because the risk of relapse in women during this time is high.

Further information

Further information on serious mental illness can be accessed from the relevant NICE guidance from:

http://guidance.nice.org.uk/CG38

http://guidance.nice.org.uk/CG45

http://www.sign.ac.uk/guidelines/131

Indicator area: Chronic obstructive pulmonary disease (self-management)

Indicators

10. The percentage of patients with COPD recorded as having an exacerbation in the preceding 12 months who have been given a course of antibiotics and corticosteroids (rescue pack) as part of a personalised future exacerbation self-management strategy in the preceding 12 months.

Evidence source

NICE Chronic obstructive pulmonary disease Quality Standard (2011):

Statement 7: People who have had an exacerbation of COPD are provided with individualised written advice on early recognition of future exacerbations, management strategies (including appropriate provision of antibiotics and corticosteroids for self-treatment at home) and a named contact.

NICE clinical guideline 101: Chronic obstructive pulmonary disease: Management of chronic obstructive pulmonary disease in adults in primary and secondary care (partial update) (2010):

Recommendation 1.2.12.21: Patients at risk of having an exacerbation of COPD should be given self-management advice that encourages them to respond promptly to the symptoms of an exacerbation.

Recommendation 1.2.12.22: Patients should be encouraged to respond promptly to the symptoms of an exacerbation by:

- starting oral corticosteroid therapy if their increased breathlessness interferes with activities of daily living (unless contraindicated)
- starting antibiotic therapy if their sputum is purulent
- adjusting their bronchodilator therapy to control their symptoms

Recommendation 1.2.12.23: Patients at risk of having an exacerbation of COPD should be given a course of antibiotic and corticosteroid tablets to keep at home for use as part of a self-management strategy.

Brief rationale for indicator(s)

There is evidence to suggest that if used correctly self-management plans for people with COPD who have had an exacerbation will often lead to patients starting courses of antibiotics or oral steroids that they have been given to keep at home, and may lead to reduced hospital admissions.

This potential new QOF indicator for COPD would incentivise the provision of a rescue pack as part of a personalised future exacerbation self-management strategy for people with COPD who have had a previous exacerbation.

Topic overview

Chronic obstructive pulmonary disease (COPD) is an overarching term used to describe a number of conditions including chronic bronchitis, emphysema, chronic obstructive airways disease and chronic airflow limitation. COPD is a chronic disorder characterised by consistent airflow obstruction and is associated with persistent and progressive breathlessness, a chronic productive cough and limited exercise capacity. The airflow obstruction is usually progressive, not fully reversible and does not change markedly over several months. About 900,000 people have diagnosed COPD. Prevalence increases with age (it is rare before 35 years of age) and is mostly associated with smoking. COPD remains the fifth most common cause of death in England and Wales, accounting for more than 28,000 deaths in 2005 and is the second largest cause of emergency admission in the UK, with one in eight (13,000) emergency admissions to hospital as a result of COPD. One fifth (21%) of bed days used for respiratory disease treatment are due to chronic obstructive lung disease, such that COPD accounts for more than one million 'bed days' each year in hospitals in the UK.

Further information

Further information on managing exacerbations can be accessed from the relevant NICE guidance on chronic obstructive pulmonary disease from:

http://guidance.nice.org.uk/CG101

Appendix B: Consultation proforma

Potential new indicators for QOF

Consultation dates: 6th January – 3rd February 2014

General Comments

Stakeholders are welcomed to submit comments in **Table 1** for all indicators based on the following set of questions:

1. Do you think there are any barriers to the implementation of the care described by any of these indicators?

2. Do you think there are potential unintended consequences associated with the implementation of any of these indicators?

3. Do you think there is potential for differential impact (in respect of age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation), if so please state whether this is adverse or positive and for which group?

4. If you think any of these indicators may have an adverse impact on different groups in the community, can you suggest any guidance on adaptation to the delivery of the indicator which might reduce health inequalities?

In addition to the above questions, stakeholders are invited to comment on the following indicator specific questions:

5. Indicator 1: Retinal screening is not currently included within this composite indicator as it was considered to be outside the control of GPs. Do stakeholders consider it appropriate to include retinal screening in this indicator?

6. Indicator 4: The QOF Advisory Committee recommended that indicators to assess target organ damage focus on tests used in primary care for renal damage and electrocardiographs. Do stakeholders consider the indicators in piloting will provide an adequate assessment of target organ damage?

7. Indicator 6: From a patient perspective do stakeholders consider screening for hazardous or harmful alcohol consumption in people with a new diagnosis of hypertension and where necessary, subsequent feedback and information appropriate?

8. Indicators 2 – 6: Which of these indicators, relating to hypertension, do stakeholders feel are the highest priority for the QOF?

9. Indicator 7: The age range for this indicator is under review. Do stakeholders feel that age 65 years and over is an appropriate age range for this indicator? If no, please suggest an alternative age range that should be applied to the indicator.

10. Indicator 7: The number of drugs prescribed for this indicator is under review. Do stakeholders feel that 10 drugs is an appropriate number to prompt a medication review? If no, please suggest an alternative number that should be applied to the indicator

11. Indicator 8 & 9: From a patient perspective do stakeholders consider annual provision of pregnancy, conception or contraception advice to people with SMI appropriate?

12. Indicator 8 & 9: Indicators 8 and 9 relate to people with serious mental illness. Which of these indicators do stakeholders feel is the highest priority for the QOF?

How to submit your comments

If you would like to comment on any of the 10 indicators currently being consulted on please use the comments proforma and forward this to Lisa Nicholls at indicators@nice.org.uk.

PLEASE NOTE: The Institute reserves the right to summarise and edit comments received during consultations, or not to publish them at all, where in the reasonable opinion of the Institute, the comments are voluminous, publication would be unlawful or publication would be otherwise inappropriate.

Comments proforma

Consultee name:		Consultee organisation:	

Table: Comments on indicators

Indicator Area	Indicator	Consultee comments
Diabetes	1. The percentage of patients with diabetes who have had the following care processes performed in the preceding 12 months: • BMI measurement • BP measurement • HbA1c measurement • Cholesterol measurement • Record of smoking status • Foot examination • Albumin: creatinine ratio • Serum creatinine measurement	See questions 1 to 4 above
	Indicator specific question: Retinal screening is not currently included within this composite indicator as it was considered to be outside the control of GPs. Do stakeholders consider it appropriate to include retinal screening in this indicator?	
	2. The percentage of patients with a new diagnosis of hypertension in the preceding 1st April to 31st March who have a record of urinary albumin: creatinine ratio test in the three months before or after the date of entry to the hypertension register	See questions 1 to 4 above

Indicator Area	Indicator	Consultee comments
Hypertension	3. The percentage of patients with a new diagnosis of hypertension in the preceding 1st April to 31st March who have a record of a test for haematuria in the three months before or after the date of entry to the hypertension register.	See questions 1 to 4 above
	4. The percentage of patients with a new diagnosis of hypertension in the preceding 1st April to 31st March who have a record of a 12 lead ECG performed in the three months before or after the date of entry to the hypertension register.	See questions 1 to 4 above
	Indicator specific question: The QOF Advisory Committee recommended that indicators to assess target organ damage focus on tests used in primary care for renal damage and electrocardiographs. Do stakeholders consider the indicators in piloting will provide an adequate assessment of target organ damage?	
	5. The percentage of patients with a new diagnosis of hypertension in the preceding 1st April to 31st March who have been screened for hazardous or harmful alcohol consumption using a validated tool in the three months before or after the date of entry on the hypertension register.	See questions 1 to 4 above
	6. The percentage of patients with a new diagnosis of hypertension in the preceding 1st April to 31st March who screen positive for hazardous or harmful alcohol consumption who have been given personalised feedback on their AUDIT score and a patient information leaflet about their level of alcohol related risk or harm within three months of the AUDIT score being recorded.	See questions 1 to 4 above

Indicator Area	Indicator	Consultee comments
	Indicator specific question: From a patient perspective do stakeholders consider screening for hazardous or harmful alcohol consumption in people with a new diagnosis of hypertension and where necessary, subsequent feedback and information appropriate?	
	Indicator specific question: Indicators 2 - 6 relate to people with hypertension. Which of these indicators do stakeholders feel are the highest priority for the QOF?	
Polypharmacy	7. The percentage of patients aged 65 years and over who are prescribed 10 or more medications that have had a face to face medication review in the preceding 12 months.	See questions 1 to 4 above
	Indicator specific question: The age range for this indicator is under review. Do stakeholders feel that age 65 years and over is an appropriate age range for this indicator? If no, please suggest an alternative age range that should be applied to the indicator.	
	Indicator specific question: The number of drugs prescribed for this indicator is under review. Do stakeholders feel that 10 drugs is an appropriate number to prompt a medication review? If no, please suggest an alternative number that should be applied to the indicator.	
Serious mental illness	8. The percentage of women with schizophrenia, bipolar affective disorder or other psychoses under the age of 45 years who have been given information and advice about pregnancy, conception or contraception tailored to their pregnancy and contraceptive intentions recorded in the preceding 12 months.	See questions 1 to 4 above

Indicator Area	Indicator	Consultee comments
	9. The percentage of women with schizophrenia, bipolar affective disorder or other psychoses aged 45 years or less who have been prescribed psychotropic medication in the preceding 12 months who have been advised of the risks of these medications during pregnancy in the preceding 12 months.	See questions 1 to 4 above
	Indicator specific question: From a patient perspective do stakeholders consider annual provision of pregnancy, conception or contraception advice to people with serious mental illness appropriate?	
	Indicator specific question: Indicators 8 and 9 relate to people with serious mental illness. Which of these indicators do stakeholders feel is the highest priority for the QOF.	
Chronic obstructive pulmonary disease	10. The percentage of patients with COPD recorded as having an exacerbation in the preceding 12 months who have been given a course of antibiotics and corticosteroids (rescue pack) as part of a personalised future exacerbation self-management strategy in the preceding 12 months.	See questions 1 to 4 above