

NICE Indicators Programme

Consultation on potential new indicators

Consultation dates: 1–29 February 2016

This document outlines potential new indicators for inclusion in the [NICE indicator menu](#). The NICE indicator menu includes indicators on many different topics that can be used for a range of purposes.

In this document, indicators are grouped according to clinical area. The intended use for each indicator is also given. These are:

- general practice indicators suitable for incentivisation (QOF)
- general practice indicators for quality improvement, for example to support local schemes
- clinical commissioning group outcome indicators.

We welcome general comments and ask stakeholders to respond to some key questions. Feedback from this consultation alongside other parts of the indicator development process will be presented to the NICE Indicator Advisory Committee in mid-2016.

The proposed indicators may change following consultation.

Please read the introductory text included in this document before submitting your comments. If you have any questions about this consultation please contact the NICE Indicator Team (indicators@nice.org.uk).

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NICE is currently piloting and testing 5 QOF/general practice indicators relating to cardiovascular disease. These 5 indicators are not included in this consultation. The findings from piloting and testing will be used to inform future work on these indicators.

Introduction

The types of indicator and how they can be used

NICE has a remit to develop indicators for potential inclusion in the General Medical Services QOF. NHS England and the devolved administrations use the NICE indicator menu to help decide which indicators are included in the QOF within their countries. In this document, indicators called 'general practice indicators suitable for incentivisation' are ones that could be considered for inclusion in the QOF.

This document also includes some general practice indicators for quality improvement. These indicators are not suitable for inclusion in national incentive schemes such as the QOF at this time, but could be used as part of local or national quality improvement initiatives. At time of publication these indicators have not been through the full development process that NICE uses to develop QOF indicators. In this document, these indicators are called 'general practice indicators for quality improvement'.

NICE also has a remit to develop indicators for inclusion in NHS England's Clinical Commissioning Group Outcome Indicator Set (CCG OIS). In this document, indicators called 'clinical commissioning group outcome indicators' are ones that could be considered for inclusion in the CCG OIS.

How we develop indicators and the purpose of consultation

All NICE indicators are developed in accordance with the [NICE indicator development process](#). A key part of this process is giving stakeholders the opportunity to comment on the proposed indicators and the intended use of the indicator.

As part of the consultation, stakeholders are asked to respond to some key questions about all the indicators. We also ask for feedback on some specific points. These come from discussions that are held at the [NICE Indicator Advisory Committee \(IAC\)](#).

How to submit your comments

Please send your comments using the [form available](#) on the NICE website to indicators@nice.org.uk by 5 pm on 29 February 2016.

Indicators by topic

Antenatal care

<i>Antenatal care – seen for booking by 10 weeks</i>	
Indicator ID and draft wording	IND CCG1: The proportion of pregnant women accessing antenatal care who are seen for booking by 10 weeks 0 days
Intended purpose	Clinical commissioning group outcome indicator
Existing indicator	2015/2016 CCG OIS: Indicator C1.13: Antenatal assessments within 13 weeks
Indicator rationale	<p>Pregnant women accessing antenatal care should be seen early in their pregnancy in order to determine if there is a need for additional care. NICE guidance recommends 3 audit targets during gestation: 10 weeks, 12 weeks + 6 days (13 weeks) and 20 weeks of pregnancy.</p> <p>This indicator is being considered as the current indicator focused on 13 weeks has high achievement levels.</p>
Evidence base / NICE QS¹	<p>This indicator is supported by recommendation 1.1.1.1 from NICE guideline on antenatal care.</p> <p>NICE QS22 – antenatal care – statement 1</p>

¹ Where possible the indicators have been mapped to NICE quality standards

Atrial fibrillation

<i>Identifying undiagnosed atrial fibrillation (people with comorbidities)</i>	
Indicator ID and draft wording	IND GP1: Of those patients registered at the practice aged 65 years and over who have been diagnosed with one or more of the following conditions hypertension, diabetes, CKD, PAD, stroke or COPD and who have had at least one consultation in the preceding 12 months: the proportion that have had a manual pulse palpation on at least one occasion.
Intended purpose	General practice indicator for quality improvement.
Indicator rationale	<p>Atrial fibrillation is a major risk factor for stroke and is a contributing factor for 1 in 5 strokes. It is estimated that up to 440,000 adults are not identified on the register for atrial fibrillation and as a result will not be receiving the appropriate management to reduce their risk of stroke.</p> <p>Atrial fibrillation can be diagnosed by performing a manual pulse palpation to assess for an irregular pulse followed by an electrocardiogram (ECG) where an irregular pulse has been detected. Checking for an irregular pulse should form part of any blood pressure measurement. Blood pressure measurement is recommended in patients with hypertension, diabetes, CKD, PAD or previous stroke and therefore a manual pulse palpation should also be performed in these patients to assess for an irregular pulse. Atrial fibrillation is also more likely in people with COPD (Stroke Association, 2015).</p> <p>Figures from Health and Social Care Information Centre, trend in consultation rates in general practice – 1995 – 2009, show that people aged 65 years and over on average attend general practice around 6 times a year.</p>
Evidence base	This indicator is supported by recommendation 1.1.1 from NICE guideline on atrial fibrillation , recommendations 1.1.2 and 1.2.1 from NICE guideline on hypertension , recommendations 1.13.1 (type 1) and 1.4.1 (type 2) from NICE guidelines on type 1 and type 2 diabetes in adults, recommendation 1.6.1 from NICE guideline on CKD , recommendation 1.2.1 from NICE guideline on PAD and recommendation 1.5.3.2 from NICE guideline on stroke .
Issues for consideration during consultation: <ul style="list-style-type: none"> Can respondents comment on access to ECG services? People with chronic conditions were identified as an appropriate population for manual pulse palpation. Do stakeholders consider the range of the conditions covered in the indicator suitable? 	

<i>Identifying undiagnosed atrial fibrillation (people aged 65 years and over)</i>	
Indicator ID and draft wording	IND GP2: Of those patients registered with the practice aged 65 years and over who have had at least one consultation in the preceding 12 months: the percentage that has had a manual pulse palpation on at least one occasion.
Intended purpose	General practice indicator for quality improvement.
Indicator rationale	<p>Atrial fibrillation is a major risk factor for stroke and is a contributing factor for 1 in 5 strokes. It is estimated that up to 440,000 adults are not identified on the register for atrial fibrillation and as a result will not be receiving the appropriate management to reduce their risk of stroke.</p> <p>Atrial fibrillation can be diagnosed by performing a manual pulse palpation to assess for an irregular pulse followed by an electrocardiogram (ECG) where an irregular pulse has been detected. Checking for an irregular pulse should form part of any blood pressure measurement. The prevalence of atrial fibrillation increases with age and therefore is more likely in those aged 65 years and over.</p> <p>Figures from Health and Social Care Information Centre, trend in consultation rates in general practice – 1995 – 2009, show that people aged 65 years and over on average attend general practice around 6 times a year.</p>
Evidence base	This indicator is supported by recommendation 1.1.1 from NICE guideline on atrial fibrillation .
Issues for consideration during consultation:	
<ul style="list-style-type: none"> • Can respondents comment on access to ECG services? 	

Anticoagulation to prevent stroke

Indicator ID and draft wording	IND QOF1: The percentage of patients with atrial fibrillation and a CHA ₂ DS ₂ -VASC of ≥2 at any time who are not currently treated with anticoagulant therapy who have had a review of the risks and benefits of anticoagulation in the preceding 12 months
Intended purpose	General practice indicator suitable for incentivisation.
Existing indicators	<p>There is an indicator active in the 2015/16 QOF around offering people anticoagulation who have a CHA₂DS₂-VASC of ≥2:</p> <p>In those patients with atrial fibrillation with a record of a CHA2DS2-VASC score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy.</p>
Indicator rationale	<p>Appropriate anticoagulation can help to prevent stroke in people with atrial fibrillation. All people with atrial fibrillation and a CHA₂DS₂-VASC score of two or above should be offered anti-coagulation therapy.</p> <p>In people with atrial fibrillation and a CHA₂DS₂-VASC score of two or above who are not taking anticoagulation a review of risks and benefits of anticoagulation should take place annually to ensure that they are aware of the benefits of stroke prevention. Available anticoagulation options should include vitamin K antagonists such as warfarin and non-vitamin K antagonist oral anticoagulants (NOACS).</p>
Evidence base / NICE QS	<p>This indicator is supported by recommendations 1.5.3 and 1.5.4 from the NICE guideline on atrial fibrillation.</p> <p>NICE QS93 – atrial fibrillation – statement 1</p>
Issues for consideration during consultation:	
<ul style="list-style-type: none"> • To what extent would this already happen as routine practice during consultations with this population • Does this indicator expand on the indicator currently in the 2015/16 QOF? 	

Review of anticoagulation

Indicator ID and draft wording	IND QOF2: The proportion of people with atrial fibrillation who are prescribed anticoagulation who have a review of the need for and quality of anticoagulation in the preceding 12 months
Intended purpose	General practice indicator suitable for incentivisation.
Indicator rationale	<p>Appropriate anticoagulation can help to prevent stroke in people with atrial fibrillation by reducing the likelihood of a blood clot forming. However if anticoagulation with a vitamin K antagonist is poorly controlled or adherence to any anticoagulation is poor, prevention will be suboptimal.</p> <p>In order to ensure that appropriate anticoagulation is being taken, people with atrial fibrillation should have a review, to decide whether they are taking the right type of anticoagulation as well as discussing any challenges in adherence and control. Available anticoagulation options should include vitamin K antagonists such as warfarin and non vitamin K antagonist oral anticoagulants (NOACS).</p>
Evidence base / NICE QS	<p>This indicator is supported by recommendation 1.5.18 from the NICE guideline on atrial fibrillation.</p> <p>NICE QS93 – atrial fibrillation – statement 3</p>

Stroke rates in people with atrial fibrillation

Indicator IDs and draft wording	IND CCG2: Stroke rates in people with atrial fibrillation
Intended purpose	Clinical commissioning group outcome indicators
Indicator rationale	<p>Stroke that is preceded by atrial fibrillation is a significant contributor to morbidity and mortality and is estimated to cost the NHS in England around £196 million.</p> <p>NHS Improvement (2011) estimate that adequate management of atrial fibrillation can prevent around 8,000 of these strokes.</p> <p>This indicator measures rate of stroke preceded by atrial fibrillation and improvements in identification and treatment of atrial fibrillation should be reflected by lower stroke rates.</p>
Evidence base	Outcome measures not attributable to a single guideline.

Issues for consideration during consultation

- If the data are available should this indicator being expanded to include:
 - Infarction stroke rates in people with atrial fibrillation
 - Intracerebral haemorrhage stroke rates in people with atrial fibrillation
 - TIA rates in people with atrial fibrillation

Chronic kidney disease

<i>Chronic kidney disease - register</i>	
Indicator ID and draft wording	IND QOF3: The contractor establishes and maintains a register of patients aged 18 or over with CKD
Intended purpose	General practice indicator suitable for incentivisation.
Existing indicator	<p>There is a CKD register indicator active in the 2015/16 QOF:</p> <p>The contractor establishes and maintains a register of patients aged 18 or over with CKD with classification of categories G3a to G5 (previously stage 3 to 5).</p>
Indicator rationale	<p>The 2014/15 QOF register for CKD reported a prevalence of 4.13% for CKD stage 3-5. The NICE guideline for CKD (CG182) recommends classifying CKD using a combination of ACR and GFR categories, noting that:</p> <ul style="list-style-type: none">• increased ACR is associated with increased risk of adverse outcomes• decreased GFR is associated with increased risk of adverse outcomes• increased ACR and decreased GFR in combination multiply the risk of adverse outcomes. <p>The guideline (CG182) recommends that people with CKD are managed according to the care algorithm presented in appendix A of this document</p>
Evidence base	This indicator is supported by recommendations 1.1.27, 1.1.28, 1.1.29 and 1.2.1 from the NICE guideline on chronic kidney disease
Issues for consideration during consultation	
<ul style="list-style-type: none">• Would expansion of the CKD QOF register to include people with early stages of CKD have clinical value?	

Diabetes

HbA1c targets	
Indicator IDs and draft wording	<p>IND QOF4: The percentage of patients with diabetes in whom the last IFCC-HbA1c is 53 mmol/mol or less in the preceding 12 months.</p> <p>IND QOF5: The percentage of patients with diabetes in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months.</p>
Intended purpose	General practice indicators suitable for incentivisation
Existing indicators	<p>There are indicators active in the 2015/16 QOF around HbA1c targets:</p> <p>The percentage of patients with diabetes in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months.</p> <p>The percentage of patients with diabetes in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months.</p> <p>The percentage of patients with diabetes in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months.</p>
Indicator rationale	<p>In 2013, around 2.9 million people were diagnosed with diabetes in England. The diabetes QOF register for 2014/15 reports a recorded prevalence of 6.4%, this compares to a recorded prevalence of 6.2% for 2013/14. Diabetes UK estimated that treating diabetes and its complications cost the UK £14 billion in 2012.</p> <p>Poor blood glucose control is associated with increased risk of vascular complications. Therefore one of the main objectives of care for people with both type 1 and type 2 diabetes is to minimise the risk of these complications through optimised glycaemic control.</p> <p>For type 1 diabetes, NICE guidance recommends that diabetes services document the proportion of adults who achieve an HbA1c of 53 mmol/mol (7%) or lower. The recommended management strategy for type 2 diabetes is to intensify drug treatment if HbA1c levels rise to 58 mmol/mol (7.5%) with a target of 53 mmol/mol (7.0%) to achieve glycaemic control.</p>
Evidence base	This indicator is supported by recommendation 1.6.8 from the NICE guideline on type 2 diabetes in adults and recommendation 1.6.9 from the NICE guideline on type 1 diabetes in adults

Type 1 diabetes - statin therapy

Indicator ID and draft wording	IND QOF6: Of the patients with type 1 diabetes who meet the following criteria: aged over 40 years and who have either had diabetes for more than 10 years, or who have established nephropathy or other CVD risk factors; the percentage currently treated with a statin.
Intended purpose	General practice indicator suitable for incentivisation
Indicator rationale	<p>Cardiovascular risk is elevated in people with type 1 diabetes and NICE guidance recommends that statin therapy be considered in all people with type 1 diabetes and offered to those with additional risk factors, such as, nephropathy.</p> <p>Statin therapy is associated with a reduction of fatal and non-fatal myocardial infarction (MI) and the composite outcome coronary heart disease death or non-fatal MI, fatal and nonfatal stroke and revascularisation. When assessed against the critical outcomes all-cause mortality, cardiovascular mortality, non-fatal MI and quality of life, high and medium intensity statin therapy have a beneficial effect on non-fatal MI.</p>
Evidence base	This indicator is supported by recommendation 1.3.24 from the NICE guideline on lipid modification .

Diabetes in pregnancy

Indicator IDs and draft wording	IND CCG3: The proportion of pregnant women with pre-existing diabetes who have a joint diabetes and antenatal care team review within 1 week of referral. IND CCG4: The proportion of pregnant women diagnosed with gestational diabetes that have a joint diabetes and antenatal care team review within 1 week of diagnosis.
Intended purpose	Clinical commissioning group outcome indicators.
Indicator rationale	Women with diabetes who become pregnant need extra care in addition to routine antenatal care. Members of the joint diabetes and antenatal care team are able to ensure that specialist care is delivered to minimise adverse pregnancy outcomes. Immediate access to the joint diabetes and antenatal care team within 1 week of pregnancy being confirmed or 1 week of diagnosis of gestational diabetes will help to ensure that a woman's diabetes is controlled during early pregnancy, when there is an increased risk of fetal loss and anomalies. It will also help to ensure that the woman's care is planned appropriately throughout her pregnancy.
Evidence base / NICE QS	This indicator is supported by recommendation 1.2.9 from the NICE guideline on diabetes in pregnancy . NICE QS109 – diabetes in pregnancy – statements 2 and 5

Annual diabetes test following gestational diabetes

Indicator ID and draft wording	IND GP3: The proportion of women with a history of gestational diabetes who have had an HbA1c recorded in the preceding 12 months.
Intended purpose	General practice indicator for quality improvement.
Indicator rationale	Women who have had gestational diabetes are at increased risk of developing type 2 diabetes either in the immediate postnatal period or in the future. Early detection of type 2 diabetes through annual HbA1c testing in primary care can delay disease progression and reduce the risk of complications
Evidence base / NICE QS	This indicator is supported by recommendation 1.6.14 from the NICE guideline on diabetes in pregnancy . NICE QS109 – diabetes in pregnancy – statement 7

Complications of diabetes

Indicator ID and draft wording	IND CCG5: Admission rates due to complications associated with diabetes
Intended purpose	Clinical commissioning group outcome indicator
Existing indicators	2015/2016 CCG OIS indicator: C2.8: Complications associated with diabetes, including emergency admission for diabetic ketoacidosis and lower limb amputation NICE menu indicator CCG15: The proportion of adults with diabetes who have an emergency admission for diabetic ketoacidosis.
Indicator rationale	In 2009/10 there were 116,884 admissions for inpatient care for diabetic foot problems in England, leading to 1,222,200 bed days (JDBS IP, 2013). Diabetes is the most common cause of non-traumatic limb amputation, with diabetic foot ulcers preceding more than 80% of amputations in people with diabetes. After a first amputation, people with diabetes are twice as likely to have a subsequent amputation as people without diabetes.
Evidence base	Outcome measure not attributable to a single guideline.

Diabetes in children and young people

Indicator ID and draft wording	IND CCG6: Proportion of children and young people who receive the following individual care processes:
	<ul style="list-style-type: none"> • Glycated Haemoglobin A1c (HbA1c) monitoring • Body Mass Index (BMI) • Blood pressure • Urinary Albumin • Cholesterol • Eye screening • Foot examination • Smoking • Screening for thyroid and coeliac disease • Psychological assessment
Intended purpose	Clinical commissioning group outcome indicators
Indicator rationale	The National Paediatric Diabetes Audit highlights that in England and Wales there are 26,500 cases of type 1 and 500 cases of type 2 diabetes (NPDA, 2014). The risk of complications associated with diabetes in children and young people can be reduced by monitoring care through carrying out a number of care processes. The nine care processes included in this indicator are recommended by NICE for children and young people with diabetes. This indicator would complement an indicator currently on the NICE menu that measures diabetes care processes in adults.
Evidence base	This indicator is supported by recommendations 1.3.20, 1.3.50, 1.2.12, from the NICE guideline on diabetes (type 1 and type 2) in children and young people .
Issue for consideration during consultation:	
<ul style="list-style-type: none"> • If the data are available should this indicator be further broken down into age bands of perhaps 5 years – so, 0 – 5 years, 5 – 10 years, and 10 – 15 years etc. 	

Diabetic eye screening

Indicator ID and draft wording	IND CCG7: The percentage of people with diabetes aged 18 years and older who have a record of retinal screening in the past 12 months
Intended purpose	Clinical commissioning group outcome indicator
Existing indicators	2015/2016 CCG OIS indicator: C2.4: People with diabetes who have received nine care processes (eye check/retinopathy screening) NICE menu for the QOF (NM98): The percentage of patients with diabetes, on the register, who have a record of retinal screening in the preceding 12 months
Indicator rationale	Poor management of diabetes can lead to serious complications such as diabetic retinopathy. Diabetic eye screening helps to identify people who are at risk of sight loss which can lead to interventions such as treatment with laser therapy to reduce this risk In 2011 The National Screening Committee found that of those screened 5.4% required onward referral for treatment.
Evidence base	This indicator is supported by recommendation 1.7.17 from the NICE guideline on Type 2 diabetes in adults and recommendations 1.15.1 and 1.15.2 from the NICE guideline on Type 1 diabetes in adults .

Learning disabilities and autism

<i>Annual health assessment in people with learning disabilities</i>	
Indicator ID and draft wording	IND GP4: The percentage of patients with a learning disability who have received a health assessment in the preceding 12 months.
Intended purpose	General practice indicator for quality improvement.
Indicator rationale	Annual health checks in people with a learning disability are likely to lead to identification and management of underlying physical health problems at an early stage. Unrecognised physical illness in people with a learning disability may lead to pain and discomfort, which, in turn, may be an important factor in triggering and maintaining behaviour that challenges. Therefore, early identification of physical health problems in people with a learning disability may reduce behaviour that challenges, leading to a reduction in costs associated with assessing and managing such behaviour.
Evidence base / NICE QS	This indicator is supported by recommendations 1.2.1 from the NICE guideline on <u>Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges.</u> NICE <u>QS101</u> – learning disabilities: challenging behaviour – statement 1

<i>Non-elective admissions for people with learning disabilities and autism</i>	
Indicator ID and draft wording	IND CCG8: Rates of non-elective admissions for people with learning disabilities and or autism to mental health and general hospital settings
Intended purpose	Clinical commissioning group outcome indicators
Indicator rationale	High numbers of non-elective admissions for people with learning disabilities and or autism can be an indication of poor care planning and provision. Evidence suggests that people in this group have disproportionately high levels of hospital admissions to both general and mental health inpatient care and in some cases these could be avoided with better care planning and provision.
Evidence base	Outcome measure not attributable to a single guideline.

Weight management

Recording of BMI	
Indicator ID and draft wording	IND QOF7: The percentage of patients aged 18 or over who have had a record of a BMI being calculated in the preceding 5 years.
Intended purpose	General practice indicator suitable for incentivisation.
Indicator rationale	<p>There will be an estimated 11 million more obese adults in the UK by 2030 with combined medical costs for treatment of associated diseases estimated to increase by up to £2 billion per year. Obesity is associated with an increased risk of developing a number of chronic diseases and conditions including type 2 diabetes, coronary heart disease, hypertension and stroke, asthma and back pain. Weight loss can also be an important clinical factor in the diagnosis and management of a number of conditions. Many health complications can be reduced by weight loss through dietary change, increased physical activity and behavioural interventions.</p> <p>Calculating BMI will enable primary care to identify people who are overweight and obese, which can then lead to primary care playing a key role in weight management through assessing risk and morbidity, and facilitating access to weight management support.</p>
Evidence base	This indicator is supported by recommendations 1.2.1 and 1.2.2 from the NICE guideline on obesity

Weight management advice

Indicator wording and ID	IND QOF8: The percentage of patients aged 18 years and above with a BMI ≥ 25 in the preceding 12 months who have been given appropriate weight management advice within 90 days of their BMI being recorded.
Intended purpose	General practice indicator suitable for incentivisation.
Indicator rationale	<p>Statistics show that 26% of adults are obese (BMI ≥ 30) with a greater proportion being either overweight or obese - 67% of men and 57% of women (Health and Social Care Information Centre, 2014). Being overweight may lead to significant health problems and is directly linked to several illnesses including type 2 diabetes, hypertension, fatty liver disease, gallstones and gastro-oesophageal reflux disease, as well as psychological and psychiatric morbidities. Targeting people who are overweight reflects a pro-active approach to preventing and reducing obesity and its associated complications in line with vision set out in the NHS Five Year Forward View (NHS England, 2014).</p> <p>NICE guidance recommends that people who are classified as overweight with a BMI of 25 or over should be involved in a discussion with a health professional regarding their weight and given general advice on weight and lifestyle.</p>
Evidence base	This indicator is supported by recommendation 1.4.2 from the NICE guidance on obesity and recommendation 6 from the NICE public health guideline on managing overweight and obesity in adults

References

Joint British Diabetes Societies for Inpatient Care (2013). [Admissions avoidance and diabetes: guidance for clinical commissioning groups and clinical teams](#)

Health & Social Care Information Centre (2014) [Statistics on obesity, physical activity and diet: England 2014](#)

NHS England (2014) [Five Year Forward View](#)

NHS Improvement (2011). [The best of clinical pathway redesign: Practical examples delivering benefits to patients](#)

Royal College of Physicians (2013) [Action on obesity: comprehensive care for all](#)
[Government Statistics National Statistics](#)

Royal College of Paediatrics and Child Health. National Paediatric Diabetes Audit [report](#) (2014)

Stroke Association (2015). [AF: How can we do better?](#)

Appendix A: CKD classification using a combination of ACR and GFR

NICE National Institute for
Health and Care Excellence

Classification and referral for specialist assessment

Algorithm B

GFR categories (ml/min/1.73m ²) Description and range	ACR categories (mg/mmol) Description and range		
	A1	A2	A3
	Normal to mildly increased	Moderately increased	Severely increased
	<3	3–30	>30
G1 Normal and high ≥90			
G2 Mild reduction related to normal range for a young adult	60–89	No CKD in the absence of markers of kidney damage	<p>Manage in primary care according to recommendations (see algorithm C)</p> <p>Refer for specialist assessment if the person has:</p> <ul style="list-style-type: none"> - a sustained decrease in GFR of 25% or more and a change in GFR category or sustained decrease in GFR of 15 ml/min/1.73 m² or more within 12 months - hypertension that remains poorly controlled despite the use of at least 4 antihypertensive drugs at therapeutic doses (see also 'Hypertension' NICE clinical guideline 127) - known or suspected rare or genetic causes of CKD - suspected renal artery stenosis <p>Refer for specialist assessment if the person has any of the criteria in A2, or:</p> <ul style="list-style-type: none"> - ACR 70 mg/mmol or more, unless known to be caused by diabetes and already appropriately treated - haematuria
G3a Mild–moderate reduction	45–59		
G3b Moderate–severe reduction	30–44		
G4 Severe reduction	15–29		
G5 Kidney failure	<15		Refer for specialist assessment

For guidance on frequency of GFR monitoring, see recommendation 1.3.2 in the NICE guideline. For guidance on referral, see also recommendations 1.5.1 to 1.5.5

Abbreviations: ACR, albumin creatinine ratio; CKD, chronic kidney disease; GFR, glomerular filtration rate.

Appendix B: Consultation comments

Consultation dates: 1st February 2016 – 29th February 2015

General comments:

Stakeholders are asked to consider the following questions when commenting on the proposed indicators:

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 any of 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.

If you think any of these indicators may have an adverse impact in different groups in the community, can you suggest how the indicator might be delivered differently to different groups to reduce health inequalities?

In addition, stakeholders are invited to comment on a number of indicator specific questions.

How to submit your comments:

Please send your comments using the form available on the NICE website to indicators@nice.org.uk by **5pm on 29th February 2016**

Note: We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, publication would be unlawful or otherwise inappropriate.