NICE Indicators Programme

Consultation on potential new indicators for inclusion in the NICE Quality and Outcomes Framework (QOF) indicator menu

Consultation dates: 26 January 2015 – 23 February 2015

This consultation document outlines 12 potential new indicators for inclusion in the NICE Quality and Outcomes Framework (QOF) indicator menu. NHS England and the devolved administrations of Northern Ireland, Scotland and Wales will use the NICE QOF indicator menu to help decide which indicators are included in the 2016/17 QOF within their countries.

For each indicator the supporting evidence base and a brief rationale explaining what the indicator aims to achieve is included. NICE welcomes general comments and we also 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-2015. The proposed indicators presented in the document may change following consultation.

The Indicator Advisory Committee will recommend indicators for inclusion in the NICE menu for publication in August 2015.

Contents

Introduction 3
How to submit your comments 3
Potential new indicators for inclusion on the NICE menu 4
Severe mental illness 4
Obesity 5
Immunisations 6
Vulnerable patients 7
Vulnerable patients 8
Depression 9
Anxiety 10
Primary prevention of cardiovascular disease (risk assessment) 11
Primary prevention of cardiovascular disease (risk assessment) 12
Primary prevention of cardiovascular disease (statin therapy) 13
Primary prevention of cardiovascular disease (statin therapy) 14
Primary prevention of cardiovascular disease (general population) 15
References 16
Appendix A: Consultation comments 17

Introduction

NICE publishes a menu of indicators for potential inclusion in the Quality and Outcomes Framework (QOF), which is maintained and updated each year annually. As part of the indicator development process, stakeholders have the opportunity to comment on potential new indicators for the NICE QOF menu during a public consultation period.

Feedback from this consultation alongside other parts of the indicator development process (as outlined in the Indicators Process Guide) will be presented to the NICE Indicator Advisory Committee in mid-2015. The Committee will recommend indicators for inclusion in the NICE menu for publication in August 2015.

The final decision regarding which indicators to add and which to take out of the QOF is made through negotiation. In England, NHS Employers on behalf of NHS England, and the General Practitioners Committee on behalf of the British Medical Association decide which indicators are included in the QOF. Separate but similar negotiation processes happen within Northern Ireland, Scotland and Wales. NICE and the NICE Indicator Advisory Committee are not involved in these negotiations.

We encourage all stakeholders to comment on the 12 potential new indicators presented below. Stakeholders are invited to provide feedback on these potential indicators for the NICE QOF menu using the form provided in appendix A.

Stakeholders are encouraged to consider the Committee discussions relating to lipid modification and mental health from the minutes of the final meeting of the NICE QOF Advisory Committee on 10th December 2014 when responding to these parts of the consultation.

How to submit your comments

A form which stakeholders should use for submitting their comments will be available alongside the consultation document.

Please send your comments using the comment form to:

indicators@nice.org.uk by 5pm on 23 February 2015.

Potential new indicators for inclusion on the NICE menu

Severe mental illness	
Indicator wording	**QOF IND 1.** The percentage of patients aged between 25 and 84 years with schizophrenia, bipolar affective disorder and other psychoses who have had a CVD risk assessment performed in the preceding 12 months.
Indicator rationale	NHS England has identified parity of mental and physical health as a priority area for the development of new indicators. This proposed indicator seeks to address the premature morbidity and mortality experienced by people with a severe mental illness compared with the rest of the population. Physical and mental health are closely linked, and people with severe mental illness die an average of 15-20 years earlier than people without severe mental illness – one of the greatest health inequalities in England (NHS 2014). A combination of poor diet, weight gain and lack of physical activity contribute to high rates of cardiovascular disease and reduced life expectancy in people with psychosis, schizophrenia and bipolar affective disorder. The use of antipsychotic medication can also lead to weight gain and is linked to increased risk of long-term physical health problems, including CVD. There is evidence to suggest there is currently under-recognition and under-treatment in primary care of CVD in people with schizophrenia (Smith et al, 2013). This potential new QOF indicator aims to reduce the inequalities faced by people with schizophrenia, bipolar affective disorder and other psychoses by identifying those at high risk of CVD with the aim of early intervention.
Evidence base	This indicator is supported by recommendations 1.1.3.1, 1.1.3.6, 1.1.3.7, 1.3.3.4, 1.3.6.5, 1.5.3.1, 1.5.3.2 and 1.5.3.3 from the NICE guideline on psychosis and schizophrenia and 1.2.11, 1.2.12, 1.2.13, 1.2.14 and 1.10.14 from the NICE guideline on bipolar disorder and 1.1.8 from the NICE guideline on lipid modification.

Specific issue for consideration during consultation:

- Do stakeholders think this indicator is more or less likely to improve cardiovascular health in people with severe mental illness compared with the physical health check indicators currently included on the NICE menu of indicators?
- How does primary care currently deal with the specific needs of people with severe mental illness in relation to smoking cessation?
- How does primary care currently address weight management in people with severe mental illness?
- Do stakeholders consider there to be any specific areas of care which should be an explicit requirement of care planning in primary care for all people with severe mental illness?

Obesity	
Indicator wording	**QOF IND 2.** The percentage of patients with coronary heart disease, stroke or transient ischemic attack, diabetes, hypertension, peripheral arterial disease, heart failure, chronic obstructive pulmonary disease, asthma, osteoarthritis and/ or rheumatoid arthritis who have had a body mass index (BMI) recorded in the preceding 12 months.
Indicator rationale	The NHS report Five Year Forward View outlines the need for national action on the increasing burden of avoidable illness, including obesity (NHS 2014). 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, osteoarthritis and back pain. Statistics show that 26% of adults are obese, and 67% of men and 57% of women are either overweight or obese according to the BMI calculations (Health and Social Care Information Centre 2014). Most of the complications of obesity can be reduced by weight loss. This is generally managed through dietary change and increased physical activity, supported by behavioural interventions. Primary care has a key role in managing obesity through assessing risk and morbidity, and facilitating access to weight management support (Royal College of Physicians 2013). This potential new QOF indicator aims to address the increasing burden of obesity by identifying those people with chronic conditions whose symptoms may be helped by weight loss and supporting these people to lose weight.
Evidence base	This indicator is supported by recommendation 1 from the NICE public health guideline on managing overweight and obesity in adults and recommendations 1.2.2 and 1.2.3 from NICE clinical guideline 189 Obesity: identification, assessment and management of overweight and obesity in children, young people and adults

Specific issue for consideration during consultation:

- People with chronic conditions were identified as an appropriate population for BMI assessment as a precursor to indicators focused on intervention. Do stakeholders consider the scope of the conditions covered in the indicator suitable?

Immunisations	
Indicator wording	**QOF IND 3.** The percentage of patients with coronary heart disease, stroke or transient ischemic attack, diabetes and/ or chronic obstructive pulmonary disease who had a flu vaccination between the preceding 1 August and 31 March.
Indicator rationale	Influenza is a highly infectious illness that spreads rapidly through the coughs and sneezes of people with the infection. Flu vaccination is available every year on the NHS to protect adults at risk of flu and its complications. A flu vaccine is available free for anyone over the age of 65, pregnant women, children and adults with an underlying health condition (particularly long-term heart or respiratory disease) and children and adults with weakened immune systems. These groups are at a greater risk of complications from flu such as bronchitis or pneumonia or in some rare cases, cardiac problems, meningitis and/or encephalitis (Department of Health 2013). NICE recommends annual seasonal flu vaccination ideally between September and early November. This indicator represents a grouping of current QOF conditions for which flu vaccination is incentivised individually. A composite indicator for flu vaccinations may help to detect any differential effect upon immunisation coverage among conditions that put people at risk of complications from flu.
Evidence base	This indicator is supported by recommendation 1.2.9.1 from the NICE guideline on chronic obstructive pulmonary disease, recommendation 1.2.1.5 from the NICE guideline on chronic heart failure and NICE CKS: Immunizations - seasonal influenza

Vulnerable patients	
Indicator wording	**QOF IND 4**. The practice can produce a register of patients who are either resident in a care home or who are housebound.
Indicator rationale	The establishment of the Better Care Fund provides opportunities for local NHS services and the care home sector to develop new shared care models to deliver in-reach support to people in care homes, including medical reviews and medication reviews (Department of Health 2013). People who live in care homes and people who are housebound are potentially more vulnerable to the negative impact of polypharmacy. Evidence suggests that polypharmacy is experienced by 50% of people living in nursing homes and excessive polypharmacy by a further 24% (Onder et al. 2012)[1]. Excessive polypharmacy is associated with chronic disease, depression, pain, dyspnoea and gastrointestinal symptoms. Polypharmacy in older people can result in reduced medicines adherence, inappropriate prescribing, adverse drug reactions and reduced daily living activities. A first step to addressing the risks of increased polypharmacy in older people is a register of patients who live in care homes or who are housebound. The second potential new QOF indicator incentivising a medication review then aims to address the potential risks of polypharmacy in this group of vulnerable people.
Evidence base	These indicators are supported by recommendations 1.2.1, 1.2.7, 1.8.1, 1.8.2, 1.8.3, 1.8.4, and 1.8.5 from the NICE guideline on managing medicines in care homes.

Specific issues for consideration during consultation:

- For the purposes of piloting, 'vulnerable patients' (those potentially at increased risk of polypharmacy) has been defined as people living in a care home (either residential or nursing care home) and those who are housebound. Do stakeholders consider this an appropriate definition for the purposes of an indicator for the QOF?
- For the purposes of piloting, 'housebound' has not been defined. What do stakeholders consider an appropriate definition of 'housebound' for the purposes of an indicator for potential inclusion in the QOF?

[1] Polypharmacy is defined here as 5–9 drugs and excessive polypharmacy as 10 drugs or more.

Vulnerable patients	
Indicator wording	**QOF IND 5**. The percentage of patients recorded as being resident in a care home or housebound who have had a medication review recorded in the preceding 12 months.
Indicator rationale	The establishment of the Better Care Fund provides opportunities for local NHS services and the care home sector to develop new shared care models to deliver in-reach support to people in care homes, including medical reviews and medication reviews (Department of Health 2013). People who live in care homes and people who are housebound are potentially more vulnerable to the negative impact of polypharmacy. Evidence suggests that polypharmacy is experienced by 50% of people living in nursing homes and excessive polypharmacy by a further 24% (Onder et al. 2012)[2]. Excessive polypharmacy is associated with chronic disease, depression, pain, dyspnoea and gastrointestinal symptoms. Polypharmacy in older people can result in reduced medicines adherence, inappropriate prescribing, adverse drug reactions and reduced daily living activities. A first step to addressing the risks of increased polypharmacy in older people is a register of patients who live in care homes or who are housebound. The second potential new QOF indicator incentivising a medication review then aims to address the potential risks of polypharmacy in this group of vulnerable people.
Evidence base	These indicators are supported by recommendations 1.2.1, 1.2.7, 1.8.1, 1.8.2, 1.8.3, 1.8.4, and 1.8.5 from the NICE guideline on managing medicines in care homes.

Specific issues for consideration during consultation:

- For the purposes of piloting, a 'medication review' requires a face-to-face review of medicines and conditions with the person. Do stakeholders consider a face-to-face review appropriate for an indicator for the QOF?

[2] Polypharmacy is defined here as 5–9 drugs and excessive polypharmacy as 10 drugs or more.

Depression

Indicator wording	**QOF IND 6.** The percentage of patients with a new diagnosis of depression in the preceding QOF year whose notes record an offer of referral for psychological treatment within 3 months of the diagnosis.
Indicator rationale	The NHS report Five Year Forward View calls for an end to the traditional divide between NHS services (NHS 2014). This includes the need for more integrated mental health services. Mental illness accounts for almost a quarter of the total burden of disease but only around a quarter of people with mental health conditions are currently receiving treatment. Evidence shows that about 1 in 6 adults is affected by depression and anxiety (Royal College of Psychiatrists 2008), yet identifying and providing suitable treatment for common mental health problems can be a difficult and complex process for healthcare professionals. NICE guidelines provide advice on treatments and care for people with a common mental health problem. For people with depression and anxiety, the treatment offered should depend on the severity of the condition and should include talking therapies such as counselling, psychotherapy and cognitive–behavioural therapy. This potential new QOF indicator aims to ensure that GP teams know how to access different types of talking therapies locally and help people with depression decide on treatment options that are suitable for them.
Evidence base	These indicators are supported by recommendations 1.4.2.1, 1.4.2.2, 1.4.2.3, 1.4.2.4, 1.4.3.1, and 1.4.3.2 from the NICE guideline on depression in adults, recommendations 1.3.2, 1.3.4, 1.3.7 and 1.3.12 from the NICE guideline on common mental health disorders and quality statements 4, 6, 7, 8 and 13 from the NICE quality standard on depression in adults.

Specific issue for consideration during consultation

- For the purposes of piloting, referral for psychological treatment for anxiety and depression is covered under separate indicators. Are separate indicators for these 2 groups appropriate?

Anxiety	
Indicator wording	**QOF IND 7.** The percentage of patients with a new diagnosis of anxiety in the preceding QOF year whose notes record an offer of referral for psychological treatment within 3 months of the diagnosis.
Indicator rationale	The NHS Five Year Forward View calls for an end to the traditional divide between NHS services (NHS 2014). This includes the need for more integrated mental health services. Mental illness accounts for almost a quarter of the total burden of disease but only around a quarter of people with mental health conditions are currently receiving treatment. Evidence shows that about 1 in 6 adults is affected by depression and anxiety (Royal College of Psychiatrists 2008), yet identifying and providing suitable treatment for common mental health problems can be a difficult and complex process for healthcare professionals. NICE guidelines provide advice on treatment and care for people with a common mental health problem. For people with depression and anxiety, the treatment offered should depend on the severity of the condition and should include talking therapies such as counselling, psychotherapy and cognitive–behavioural therapy. This potential new QOF indicator aims to ensure GP teams know how to access different types of talking therapies locally and help people with anxiety decide on treatment options that are suitable for them.
Evidence base	These indicators are supported by recommendations 1.3.2, 1.3.4, 1.3.7 and 1.3.12 from the NICE guideline on common mental health disorders and statement 2 from the NICE quality standard on anxiety disorders.

Specific issue for consideration during consultation

- For the purposes of piloting, referral for psychological treatment for anxiety and depression is covered under separate indicators. Are separate indicators for these 2 groups appropriate?

Primary prevention of cardiovascular disease (risk assessment)	
Indicator wording	**QOF IND 8**. The percentage of patients aged between 25 and 84 years, with a new diagnosis of hypertension recorded between the preceding 1 April and 31 March who have had a face-to-face cardiovascular risk assessment using the QRISK2 risk assessment tool within 3 months of the date of the hypertension diagnosis.
Indicator rationale	For primary prevention of cardiovascular disease (CVD), people at risk need to be identified before CVD has become established. To assess risk in those likely to be at high-risk (for example, people with hypertension and diabetes) a validated assessment tool is needed that evaluates a range of modifiable and non-modifiable risk factors. The updated NICE guideline on lipid modification recommends QRISK2 as the screening tool of choice for full formal assessment of CVD risk. QRISK2 is recommended for use in people aged 25–84 years and prioritised for full formal risk assessment based on an estimate of CVD risk.
Evidence base	This indicator is supported by recommendation 1.1.8 from the NICE guideline on lipid modification.

Specific issue for consideration during consultation:

- NICE guidance recommends a systematic strategy to identify people likely to be at high risk **before** a full formal risk assessment is carried out. For the purposes of the QOF, people with newly diagnosed diabetes and hypertension have been pragmatically selected for a formal assessment of CVD risk. Can stakeholders suggest a method to identify people 'at high risk' of CVD for the purposes of the QOF?

Primary prevention of cardiovascular disease (risk assessment)	
Indicator wording	**QOF IND 9.** The percentage of patients aged between 25 and 84 years, with a new diagnosis of hypertension or diabetes recorded between the preceding 1 April and 31 March who have had a face-to-face cardiovascular risk assessment using the QRISK2 risk assessment tool within 3 months of the date of the diagnosis.
Indicator rationale	For primary prevention of cardiovascular disease (CVD), people at risk need to be identified before CVD has become established. To assess risk in those likely to be at high-risk (for example, people with hypertension and diabetes) a validated assessment tool is needed that evaluates a range of modifiable and non-modifiable risk factors. The updated NICE guideline on lipid modification recommends QRISK2 as the screening tool of choice for full formal assessment of CVD risk. QRISK2 is recommended for use in people aged 25–84 years and prioritised for full formal risk assessment based on an estimate of CVD risk.
Evidence base	This indicator is supported by recommendations 1.1.8 and 1.1.10 from the NICE guideline on lipid modification.

Specific issue for consideration during consultation:

- NICE guidance recommends a systematic strategy to identify people likely to be at high risk **before** a full formal risk assessment is carried out. For the purposes of the QOF, people with newly diagnosed diabetes and hypertension have been pragmatically selected for a formal assessment of CVD risk. Can stakeholders suggest a method to identify people 'at high risk' of CVD for the purposes of the QOF?

Primary prevention of cardiovascular disease (statin therapy)	
Indicator wording	**QOF IND 10.** The percentage of patients aged between 25 and 84 years, with a new diagnosis of hypertension recorded between the preceding 1 April and 31 March who have a recorded cardiovascular risk assessment score of 10% or greater who are currently treated with statins.
Indicator rationale	For people without clinical evidence of CVD, 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. The recent expiry of patents for several leading medicines and the use of cheaper generic alternatives have led to decreases in costs of many statins. High intensity statins are the most clinically effective option for primary prevention of CVD and are cost effective compared with all other options. NICE recommends high intensity statin therapy with atorvastatin 20 mg for the primary prevention of CVD in people with a 10% or greater 10-year risk of developing CVD.
Evidence base	This indicator is supported by recommendation 1.1.8 from the NICE guideline on lipid modification.

Specific issue for consideration during consultation:

- NICE guidance recommends treatment with statin therapy for anyone who has a CVD risk assessment score of 10% or greater **where lifestyle modification is ineffective or inappropriate**. Do stakeholders think lifestyle modification and statin therapy should be jointly incentivised?
- Do stakeholders think an indicator to specifically target lifestyle modification **before** statin therapy would be beneficial? For example: The percentage of patients diagnosed with hypertension (diagnosed on or after 1 April) who are given lifestyle advice in the preceding 12 months for: smoking cessation, safe alcohol consumption and healthy diet?

Primary prevention of cardiovascular disease (statin therapy)	
Indicator wording	**QOF IND 11.** The percentage of patients aged between 25 and 84 years, with a new diagnosis of hypertension or diabetes recorded between the preceding 1 April and 31 March who have a recorded cardiovascular risk assessment score of 10% or greater who are currently treated with statins.
Indicator rationale	For people without clinical evidence of CVD, 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. The recent expiry of patents for several leading medicines and the use of cheaper generic alternatives have led to decreases in costs of many statins. High intensity statins are the most clinically effective option for primary prevention of CVD and are cost effective compared with all other options. NICE recommends high intensity statin therapy with atorvastatin 20 mg for the primary prevention of CVD in people with a 10% or greater 10-year risk of developing CVD.
Evidence base	This indicator is supported by recommendations 1.1.8 and 1.1.10 from the NICE guideline on lipid modification

Specific issue for consideration during consultation:

- NICE guidance recommends treatment with statin therapy for anyone who has a CVD risk assessment score of 10% or greater **where lifestyle modification is ineffective or inappropriate**. Do stakeholders think lifestyle modification and statin therapy should be jointly incentivised?
- Do stakeholders think an indicator to specifically target lifestyle modification **before** statin therapy would be beneficial? For example: The percentage of patients diagnosed with hypertension or diabetes (diagnosed on or after 1 April) who are given lifestyle advice in the preceding 12 months for: smoking cessation, safe alcohol consumption and healthy diet?

Primary prevention of cardiovascular disease (general population)	
Indicator wording	**QOF IND 12.** The contractor establishes and maintains a register of patients with a 10-year risk of CVD of 10% or more.
Indicator rationale	CVD is the leading cause of death in England and Wales accounting for almost one-third of deaths (National Statistics). In 2010, 180,000 people died from CVD – around 80,000 of these deaths were caused by coronary heart disease and 49,000 were caused by strokes. Of the 180,000 deaths, 46,000 occurred before people were aged 75 years, and 70% of those were in men. NICE guidance (CG 181) recommends that identifying people with a 10-year risk of CVD of 10% or more and starting preventative interventions and treatment to reduce or manage their risk can help in preventing CVD.
Evidence base	This indicator is supported by recommendations 1.1.1, 1.1.4 and 1.1.6 from the NICE guideline on lipid modification.

Specific issue for consideration during consultation:

- NICE guidance (CG 181) recommends that a systematic strategy should be used to identify people who are likely to be at high risk of CVD. The guideline suggests that people with an estimated 10 year risk of CVD of 10% or more should be prioritised for further investigation and preventative treatment and interventions. Do stakeholders think it would be feasible and desirable to have a register of all patients identified as having a 10-year risk of CVD of 10% or more?

References

National Health Service (2014) Five Year Forward View

Smith DJ, Langan J, McLean G, et al. (2013). Schizophrenia is associated with excess multiple physical-health comorbidities but low levels of recorded cardiovascular disease in primary care: cross-sectional study. BMJ Open 4 ;3.

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

Department for Communities and Local Government, Department of Health, Rt Hon Norman Lamb, NHS England (2013) Better Care Fund

Royal College of Physicians (2013) Action on obesity: comprehensive care for all

Department of Health and Public Health England (2013) Flu Plan Winter 2013/14

Onder G, Liperoti R, Fialova D et al. (2012) Polypharmacy in nursing homes in Europe: results from the SHELTER study. Journal of Gerontology Series A: Biological Sciences and Medical Sciences 67A 698–704

Royal College of Psychiatrists (2008) A joint statement by the Royal College of General Practitioners (RCGP) and the Royal College of Psychiatrists (RCPSYCH)

Government Statistics National Statistics

Appendix A: Consultation comments

Consultation dates: 26 January 2015 – 23 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 any of these indicators?

2. Do you think there are potential unintended consequences to implementing 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 as set out above.

How to submit your comments:

Please send your comments using the form available on the website to indicators@nice.org.uk@nice.org.uk by **5pm on 23 February 2015**

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.