NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

INDICATOR DEVELOPMENT PROGRAMME

Consultation report

Indicator area: NHS Diabetes Prevention Programme

Consultation period: 8 February – 8 March 2017

Date of Indicator Advisory Committee meeting: 6 June 2017

Contents

Summary of indicators included in the consultation

ID	Indicator	Evidence source
GP8	The practice establishes and maintains a register of all people with a diagnosis of non-diabetic hyperglycaemia.	Type 2 diabetes: prevention in people at high risk (2012) NICE guideline PH38 recommendations 5 and 6
GP9	The percentage of people newly diagnosed with non-diabetic hyperglycaemia in the preceding 12 months who have been referred to a Healthier You: NHS Diabetes Prevention Programme for intensive lifestyle advice	Diabetes in adults (2016) NICE QS6 statement 1
GP10	The percentage of people with non-diabetic hyperglycaemia who have had an HbA1c or FPG test in the preceding 12 months.	Type 2 diabetes: prevention in people at high risk (2012) NICE guideline PH38 recommendation 6

GP8: Register

The practice establishes and maintains a register of all people with a diagnosis of non-diabetic hyperglycaemia.

Rationale

People with HbA1c values between 42 and 47 mmol/mol (6.0 – 6.4%) or fasting plasma glucose of 5.5- 6.9 mmol/l are described as having non-diabetic hyperglycaemia (NDH) and are at increased risk of developing type 2 diabetes. If these people are identified, action can be taken (such as offering dietary advice to help) to help prevent them going on to develop type 2 diabetes and associated complications.

Preventing type 2 diabetes can also potentially make significant cost savings for the NHS. Managing type 2 diabetes and its complications is estimated to cost around £8.8 billion annually in England.

Summary of consultation comments

There was some support from stakeholders for this indicator.

Stakeholders raised concerns about resource and capacity issues within GP practices e.g. time to undertake the tests and maintain the register. They specifically mentioned there may be a significant impact on pathology workload.

A stakeholder suggested the pre diabetes register should be based specifically on age and BMI. It was felt that the >45 year old CVD risk check, and the over 75 year old health check may identify two different cohorts with pre diabetes where the implications and needs for input will be quite different.

A stakeholder suggested a possible unintended consequence of this indicator may be the unnecessary anxiety of a diagnosis of pre diabetes. It was suggested that people particularly those from older age groups may also be at risk from being aggressively managed for a raised blood glucose.

Stakeholders suggested there is currently a lack of robust evidence to suggest interventions for people with pre diabetes helps to reduce overall levels of CHD, CVD, nephropathy or retinopathy.

Stakeholders highlighted that there needs to be a clear definition of non-diabetic hyperglycaemia and how this should be recorded to ensure the indicator has a consistent denominator across all GP practices.

Considerations for the advisory committee

The committee is asked to consider:

- if the register should have an upper limit.

GP9: Intensive lifestyle advice

The percentage of people newly diagnosed with non-diabetic hyperglycaemia in the preceding 12 months who have been referred to a Healthier You: NHS Diabetes Prevention Programme for intensive lifestyle advice

Rationale

Intensive lifestyle change programmes can prevent the onset of type 2 diabetes in people with non-diabetic hyperglycaemia by promoting changes in diet and physical activity.

Summary of consultation comments

Stakeholders had mixed views on this indicator. Some felt this would not add anything to what is already being provided by local services. However it was welcomed by some who highlighted the importance of taking proactive measures in those with an identified risk.

Stakeholders raised concerns this may deter good practice as some GPs are providing their own health programs which may not be counted as success under this indicator.

Stakeholders raised concerns over the staffing and resourcing implications as a result of the additional workload for primary care this indicator may cause i.e. providing the healthy lifestyle service.

Stakeholders suggested there is a lack of evidence that referral to the NHS Diabetes Prevention Programme for intensive lifestyle advice results in an improvement in patient-centred outcomes. It was also suggested there is a lack of evidence to show diagnosing “pre-diabetes” is a better motivator for lifestyle change than current practice (e.g. weighing a patient).

Stakeholders highlighted if there is a lower uptake of the programme in some groups this may inadvertently increase health inequalities.

Considerations for the advisory committee

The committee is asked to consider:

- if the indicator adds value beyond current practice within local services
- the lack of availability of NHS Diabetes Prevention Programme for intensive lifestyle advice services and possible resource impact

- whether services provided within the GP practice would be included in the numerator
- if the indicator should include any exclusions e.g. older age groups.

GP10: HbA1c measurement

The percentage of people with non-diabetic hyperglycaemia who have had an HbA1c or FPG test in the preceding 12 months.

Rationale

People with NDH are at increased risk of developing type 2 diabetes. Annual monitoring of their HbA1c or fasting plasma glucose (FPG) should ensure that any transition to type 2 diabetes is diagnosed promptly so that they can be offered appropriate treatment. The focus of this indicator is on annual monitoring so excludes people newly diagnosed with NDH in the preceding 12 months.

Summary of consultation comments

Stakeholders felt this is important as it records compliance with NICE guidance PH38, however some queried the evidence supporting the 12 month timeframe.

Stakeholders suggested time restraints and local priorities and/or structures may make this more difficult to achieve in some places than others e.g. smaller practices.

Stakeholders raised concerns about the administrative and clinical workload implications for practices and pathology laboratories that may occur as a result of ensuring people with existing NDH have an HbA1c or FPG every year.

Stakeholders queried if women with gestational diabetes would be included in this indicator.

A stakeholder commented that in practices who have already adopted this they have struggled recalling patients for further testing/intervention.

Considerations for the advisory committee

The committee is asked to consider:

- if the 12 month timeframe is appropriate
- if women with gestational diabetes would be included
- the feasibility given difficulties with recalling patients.

Appendix A: Consultation comments

ID	Proforma question no.	Stakeholder organisation	Comment
Question 8.1: Do you think there are any barriers to implementing the care described by these indicators?			
GP8	8.1	Brighton & Hove CCG	No Barriers
GP8	8.1	Diabetes UK	Appropriate recording at the GP level will be needed to ensure the reliability of this indicator. There would need to be a clear code with a clear definition for NDH that is understood by all working in GP practices. This is being piloted currently within the National Diabetes Audit to test and validate so this barrier will be overcome.
GP8	8.1	Individual comment – GP	No. Already being undertaken in Leeds
GP8	8.1	NHS Medway Clinical Commissioning Group	Depends on definition The audit we produced to support the NDPP includes people based on their HbA1c result it doesn't require them to be additionally coded as having NDH.
GP8	8.1	Obesity Group of the British Dietetic Association	It is not clear when and how these diagnoses will be made. If the register relies on opportunistic measurements there is potential that many will be missed. Time will also be required to take the tests and to develop and maintain the register. It may be easier for those working in large clinics with several staff and admin support to achieve this than smaller practices with 1-2 GPs.
GP8	8.1	Royal College of Nursing	No
GP8	8.1	Royal College of Pathologists	This would represent a possible expansion of screening for NDH and diabetes in general. This would have a significant impact on pathology workload, especially if HbA1c where to be used as a primary test for screening/diagnosis as advocated by the WHO. This potential financial burden comes at a time when pathology labs are being heavily scrutinised on cost and may resist this type of expansion, despite the benefits to patients.

ID	Proforma question no.	Stakeholder organisation	Comment
Question 8.2: Do you think there are potential unintended consequences to implementing / using these indicators?			
GP8	8.2	Brighton & Hove CCG	No
GP8	8.2	British Medical Association	Unless the interventions proposed can be shown to have a significant and cost-effective impact on population health the funds spent on this will detract for provision for other interventions.
GP8	8.2	Diabetes UK	No
GP8	8.2	Individual comment – GP	No
GP8	8.2	Royal College of Nursing	No
GP8	8.2	Royal College of Pathologists	Increased pathology costs.
GP8	8.2	The Royal College of General Practitioners	• Patients need to be informed at the point of diagnosis, or it may provoke anxiety when they access their records • There may be labelling and insurance consequences.
Question 8.3: 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.			
GP8	8.3	British Medical Association	When applied to older individuals, or those with other comorbidities, the time taken for patients to develop consequences of hyperglycaemia is likely to be greater than their life expectancy.
GP8	8.3	Crossfell Health Centre - GP	There are significant harms from 'pre-diabetic' diagnosis - a lot of anxiety is being created, particularly for elderly people who are aggressively managed for a raised BG but no diabetes. This can cause harm, but, perhaps more importantly, a great deal of anxiety and distress. I have a relative who is 85 who has been told exactly this and is now living on minimal weight watchers portions and losing weight rapidly - she was not overweight to start with. This is an example of enthusiastic application of 'guidelines' without consideration of the whole person. It has made a considerable contribution to her new onset frailty

ID	Proforma question no.	Stakeholder organisation	Comment
GP8	8.3	Diabetes UK	No – but this could be helpful to ensure that the NHS DPP is impacting appropriately on different high risk groups such as those who are white and over 40 or over 25 from African-Caribbean, Black African, or South Asian background.
GP8	8.3	Individual comment – GP	No
GP8	8.3	Obesity Group of the British Dietetic Association	Some groups may be less likely to use healthcare services. If so they are less likely to be diagnosed and followed up as a result. This adverse possibility may apply to males and some BME groups for example.
GP8	8.3	Royal College of Nursing	No
GP8	8.3	Royal College of Pathologists	Nothing specific but the usual bias and differentials that exist for these patient sub-groups are likely to persist for these conditions.
GP8	8.3	The Royal College of General Practitioners	No
Question 8.4: Do you have any general comments on these indicators?			
GP8	8.4	Boehringer Ingelheim	Boehringer Ingelheim supports the inclusion of this indicator.
GP8	8.4	British Medical Association	There remains uncertainty about whether the existing usual test performed to identify this condition (HbA1c) is the most appropriate, as the evidence for this as a predictor of future diabetes and cardiovascular complications only exists for impaired glucose tolerance. We do not believe that there is currently robust evidence for interventions in this group (as opposed to those with confirmed diabetes) reducing overall levels of CHD, CVD, nephropathy or retinopathy.
GP8	8.4	Crossfell Health Centre - GP	This should be removed completely
GP8	8.4	Diabetes UK	We are in support of this indicator. It will support the development of the evidence base for the Programme and contribute to the evidence on the impact of the NHS Diabetes [Type 2] Prevention Programme. The data will help support robust evaluation, delivery and development of the Programme.
GP8	8.4	Individual comment – GP	Essential to quantify and manage at risk population

ID	Proforma question no.	Stakeholder organisation	Comment
GP8	8.4	NHS Medway Clinical Commissioning Group	Please consult Ben McGough PHE for advice on audit and coding to support the NDPP Ben.mcgough@phe.gov.uk
GP8	8.4	Obesity Group of the British Dietetic Association	Maintaining a register of those with high BMI and/or waist circumference would identify those at risk of a range of non- communicable diseases, not just type 2 diabetes.
GP8	8.4	Royal College of Nursing	A positive step.
GP8	8.4	Royal College of Physicians	Within the Diabetes Prevention Programme data, although the requirement for a 'preDM' register for GPs is of value, it should specifically look at age and BMI in the context of such a register. It is possible that the >45 year old CVD risk check, and the over 75 year old health check will identify two quite different cohorts with 'preDM' where the implications and needs for input will be quite different.
GP8	8.4	The Royal College of General Practitioners	• It has the potential to be very useful, as long as there is clear evidence • This seems to be a logical and helpful register to maintain. • It is equally clear: • It amounts to a screening programme that is not endorsed by the National Screening Committee; and the best trial of screening for diabetes in primary care concluded that a screening programme should not be started • Given that the purpose overall of such a programme is to avoid the long term consequences of diabetes, and that they take some years to develop, it is highly unlikely to benefit many patients over the age of 70 • To introduce indicators in the face of such diversity may create more destructive and negative feelings among the primary care workforce
Question 9.1: Do you think there are any barriers to implementing the care described by this indicator?			
GP9	9.1	Brighton & Hove CCG	No
GP9	9.1	British Medical Association	Lack of local resources
GP9	9.1	Crossfell Health Centre - GP	This should be removed completely

ID	Proforma question no.	Stakeholder organisation	Comment
GP9	9.1	Diabetes UK	Healthcare professionals working in primary care (GPs and Practice nurses) need to be aware of the NHS Diabetes [Type 2] diabetes Prevention Programme. They also need to understand the local referral pathway and to record the referral appropriately.
GP9	9.1	Individual comment – GP	Patient acceptance of referral Suitable times and venues of programs
GP9	9.1	Obesity Group of the British Dietetic Association	Cost and availability of intensive lifestyle advice. In reality it is unlikely that the services would be equally available in all areas, or that intensive lifestyle advice would be the same in all areas. Long-term support may also vary by area.
GP9	9.1	Primary Care Diabetes Society	Polling our members – this is not widely available or accessible. It is felt that this may deter good practice as GPs who are doing their own health programs will not be rewarded
GP9	9.1	Royal College of Nursing	Access will be key and a range of formats to meet the need of the local population.
GP9	9.1	The Royal College of General Practitioners	• GPs and Practice Nurses make a nuanced judgement about patient activation (readiness to change) and some referrals will generate waste. Different parts of the UK have their own pre-existing organisations to support patients (for example, a well-being advisor, health coach or fitness coach may be more appropriate to determine what is the patient's greatest health priority) • There is a lack of resources and similar programmes are being shut down locally because of insufficient funding • Staffing and resourcing implications for the additional workload in primary care and the need to prioritise the frail elderly and their associated multi-morbidity • Lack of evidence that the intervention/working to the indicator/achieving the target results in an improvement in patient-centred outcomes (i.e. not biochemical or process measures). NICE is an exemplar in evidence based medicine and patient-centred care yet the indicator fails to give the patient centred-outcome it is expected to achieve and the evidence level, which informs the indicator. This is a barrier to

ID	Proforma question no.	Stakeholder organisation	Comment
			implementation • There is no evidence that diagnosing "pre-diabetes" is a better motivator for lifestyle change than current practice (e.g. weighing a patient)
Question 9.2: Do you think there are potential unintended consequences to implementing / using this indicator?			
GP9	9.2	Brighton & Hove CCG	No Maybe good to also monitor % attended as well as referred. This will encourage HCP to proactively encourage person to attend and give info about the programme rather than just being a tick box to refer
GP9	9.2	British Medical Association	Unless the interventions proposed can be shown to have a significant and cost-effective impact on population health the funds spent on this will detract for provision for other interventions.
GP9	9.2	Crossfell Health Centre - GP	This should be removed completely
GP9	9.2	Diabetes UK	No, but need to be aware that a referral to the programme does not necessarily indicate that an individual has accessed/ attended the lifestyle intervention.
GP9	9.2	Individual comment – GP	Reduction in uptake of referrals
GP9	9.2	Obesity Group of the British Dietetic Association	There may be lower uptake of the programme in some groups, which could inadvertently increase health inequalities.
GP9	9.2	Primary Care Diabetes Society	Frustartion and local initiatives being stopped as no reward
GP9	9.2	Royal College of Nursing	No, if the above is addressed.
GP9	9.2	The Royal College of General Practitioners	• Yes – it might result in the denigration of existing healthier lives programmes/intervention that are working well. It also makes 'special case' for pre-diabetes when there are so many health issues that might need to be addressed, singling it out for special attention • The majority of the adult population needs more exercise not just those with raised glucose levels. Other groups might benefit more i.e. depressed and frail. There is a the potential to medicalise a social problem

ID	Proforma question no.	Stakeholder organisation	Comment
Question 9.3: 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.			
GP9	9.3	British Medical Association	Patients with limited life expectancy may have little to gain from these interventions and may have their quality of life reduced rather than increased. We are concerned that there is insufficient evidence that intervention to reduce mild hyperglycaemia in patients who are frail is beneficial
GP9	9.3	Crossfell Health Centre - GP	Particularly the elderly who have least to gain and most to lose from this approach
GP9	9.3	Diabetes UK	Commitment by those referred to attend the lifestyle interventions in addition to an individual's personal circumstance (employment status, mobility, child care) may affect an individual's decision to be referred. The indicator will therefore not capture the reasons for lack of referral in people newly diagnosed with non-diabetes hyperglycaemia. Simply recording a referral would not capture any differential access as some patients may need more support than others to access the programme or to be motivated to attend. The way the referral is presented by healthcare professionals (and how the programme is offered locally) will be really important to ensure equality of access. Also some people identified by their GPs as having non-diabetic hyperglycaemia, may not want to attend the diabetes Prevention Programme, may be refereed to other lifestyle interventions or they may not be referred to any intervention. But these people still need to be monitored and followed up as per NICE guidance.
GP9	9.3	Individual comment – GP	No
GP9	9.3	Obesity Group of the British Dietetic Association	Uptake may be lower in some groups (e.g. males, some BME groups) than others, with potential adverse impacts on those groups. It will be important to ensure that

ID	Proforma question no.	Stakeholder organisation	Comment
			programmes are offered in a variety of community venues, in different locations which can be easily reached, at different times and that possible language barriers are addressed. In addition any special needs of participants will need to be taken into account. Long-term support will also be an important consideration.
GP9	9.3	Primary Care Diabetes Society	Yes – as with structured diabetes education – certain age and demographics are more likely to attend. Structured education is not suited for all
GP9	9.3	Royal College of Nursing	Patients of South Asian origin will be disadvantaged if a fasting blood glucose (FBG) screen is undertaken instead of HbA1c screen, as fasting blood glucose level (BGL) in this population group may miss both Neonatal diabetes mellitus with congenital hypothyroidism (NDH) and Diabetes.
GP9	9.3	The Royal College of General Practitioners	• No
Question 9.4: Do you have any general comments on this indicator?			
GP9	9.4	Boehringer Ingelheim	Boehringer Ingelheim supports the inclusion of this indicator.
GP9	9.4	British Medical Association	There are many people who are less likely to benefit from these referrals, they will include those who are already on secondary cardiovascular prevention programmes, and those with limited life expectancy. Encouraging referral for everyone may not be appropriate.
GP9	9.4	Diabetes UK	We agree with this indicator and its use in measuring the impact of the Programme as well as it being an opportunity to encourage GPs to emphasise the importance of prevention support available – thereby increasing primary care focus on helping people to lose weight and increase exercise.
GP9	9.4	Individual comment – GP	Should be offer of referral and coding acceptance/decline/reason
GP9	9.4	NHS Medway Clinical Commissioning Group	Please consult Ben McGough PHE for advice on audit and coding to support the NDPP Ben.mcgough@phe.gov.uk

ID	Proforma question no.	Stakeholder organisation	Comment
GP9	9.4	Obesity Group of the British Dietetic Association	It is important that proactive measures are taken in those with an identified risk, and we welcome this.
GP9	9.4	Primary Care Diabetes Society	Chane to appropriate advice and referral for onward support and education where available and suitable
GP9	9.4	Royal College of Nursing	HbA1c have been reported in mmol/mol since 2011- all laboratory results only report in mmols/mol. Primary care staff work with mmols/mol - % results should be removed as potentially may cause confusion.
GP9	9.4	The Royal College of General Practitioners	• Local services may already be working well and be person-centred, rather than disease-centred • It will require central mandate for local CCGs / councils / PHE to ensure that programmes actually exist
Question 10.1: Do you think there are any barriers to implementing the care described by this indicator?			
GP10	10.1	British Medical Association	Currently general practice is operating beyond its safe capacity.
GP10	10.1	Diabetes UK	No.
GP10	10.1	Individual comment – GP	No
GP10	10.1	Obesity Group of the British Dietetic Association	Time required and local priorities and/or structures which may make this more difficult to achieve in some places than others; for single handed GPs or small practices this may be very difficult to achieve.
GP10	10.1	Royal College of Nursing	No
GP10	10.1	Royal College of Pathologists	The impact on pathology testing and the related costs
GP10	10.1	The Royal College of General Practitioners	• Practices who have already adopted this practice have struggled with recall particularly with patients not activated to changes • There may be administrative and clinical workload implications for practices
Question 10.2: Do you think there are potential unintended consequences to implementing / using this indicator?			
GP10	10.2	British Medical Association	Increased activity without extra resources within general practice will inevitably result in worse care to other patient groups
GP10	10.2	Diabetes UK	No.

ID	Proforma question no.	Stakeholder organisation	Comment
GP10	10.2	Individual comment – GP	No
GP10	10.2	Obesity Group of the British Dietetic Association	If use of healthcare services and/or uptake of invitations to test are lower in some groups than others then there is the possibility of inadvertently increasing health inequalities.
GP10	10.2	Royal College of Nursing	No
GP10	10.2	Royal College of Pathologists	The impact on pathology testing and the related costs
GP10	10.2	The Royal College of General Practitioners	• The problem becomes owned by the GP/Nurse and not by the patients – subtly counteracting the message about self-care • There will be cost implications. • Some laboratories or CCGs won't do this unless the patient is diabetic
Question 10.3: 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.			
GP10	10.3	Diabetes UK	No.
GP10	10.3	Individual comment – GP	No
GP10	10.3	Obesity Group of the British Dietetic Association	Uptake may be lower in some groups (e.g. males, some BME groups) than others. It will be important to ensure that local community networks/champions are used to disseminate invitations and messages about the importance of this to encourage a high response.
GP10	10.3	Royal College of Nursing	No
GP10	10.3	Royal College of Pathologists	Nothing specific but the usual bias and differentials that exist for these patient sub-groups are likely to persist for these conditions.
GP10	10.3	The Royal College of General Practitioners	• No
Question 10.4: Do you have any general comments on this indicator?			
GP10	10.4	Boehringer Ingelheim	Boehringer Ingelheim supports the inclusion of this indicator.

ID	Proforma question no.	Stakeholder organisation	Comment
GP10	10.4	Brighton & Hove CCG	Could include testing of pts with Gestational Diabetes too. Guidance should be given as to whether pts should remain on register for ever or if Hba1c returns to normal for X yrs they should be removed otherwise could get inequity in registers .I also think adding BMI and lifestyle advice annually (as well as blood test) to reinforce messages from NDPP .If pts are gaining wt not exercising they could be referred for support to a exercise /wt loss programme
GP10	10.4	British Medical Association	We are unaware of any evidence that 12 months is the appropriate time-scale for review. This is a screening programme for diabetes in a high-risk population and as such is not covered by GMS contracts, so if this activity is desirable it must be properly commissioned
GP10	10.4	Diabetes UK	This indicator is important as it records compliance with NICE guidance PH38 on identifying people at high risk of Type 2 diabetes and early diagnosis. It further supports the development of the evidence base for the NHS DPP and the monitoring of the quality of care and support offered within the diabetes prevention, treatment and care pathway to improve clinical outcomes.
GP10	10.4	Individual comment – GP	No
GP10	10.4	NHS Medway Clinical Commissioning Group	Please consult Ben McGough PHE for advice on audit and coding to support the NDPP Ben.mcgough@phe.gov.uk
GP10	10.4	Obesity Group of the British Dietetic Association	We welcome this.
GP10	10.4	Royal College of Nursing	A positive indicator.
GP10	10.4	The Royal College of General Practitioners	• No

Appendix B: Equality impact assessment

Protected characteristics		
• Age • Disability • Gender reassignment	• Pregnancy and maternity • Race • Religion or belief	• Sex • Sexual orientation
Note: 1) The characteristic of marriage and civil partnership is protected only from unlawful discrimination. There is no legal requirement to consider the need to advance equality and foster good relations. 2) The definition of direct discrimination includes less favourable treatment of someone associated with a person with a protected characteristic, such as the carer of a disabled person.		
Socioeconomic factors		
The relevance and nature of socioeconomic factors will vary according to the quality standard topic. They may include deprivation and disadvantage associated with particular geographical areas, or other geographical distinctions (for example, urban versus rural).		
Other definable characteristics		
Certain groups in the population experience poor health because of circumstances distinct from – though often affected by – sharing a protected characteristic or socioeconomic factors. The defining characteristics of groups of this sort will emerge from the evidence (although a quality standard topic will sometimes explicitly cover such a group). Examples of groups identified are: • looked-after children • people who are homeless • prisoners and young offenders.		

Indicator Equality Impact Assessment form

Development stage: Consultation

Topic: Diabetes Prevention Programme

1.1 Have any potential equality issues been identified during consultation, and, if so, what are they?
Stakeholders commented that uptake may be lower in some groups (e.g. males, some BME groups) than others. It will be important to ensure that local community networks/champions are used to disseminate invitations and messages about the importance of this to encourage a high response.

1.2 Have any population groups, treatments or settings been excluded from coverage by the indicators at this stage in the process. Are these exclusions justified – that is, are the reasons legitimate and the exclusion proportionate?
No population groups, treatments or settings have been excluded from coverage at this stage.

1.3 Do any of the indicators make it more difficult in practice for a specific group to access services compared with another group? If so, what are the barriers to, or the difficulties with, access for the specific group?
Indicator GP9– consultation comments highlighted that patients of South Asian origin will be disadvantaged if a fasting blood glucose (FBG) screen is undertaken instead of HbA1c screen, as fasting blood glucose level (BGL) in this population group may miss both Neonatal diabetes mellitus with congenital hypothyroidism (NDH) and Diabetes.

1.4 Is there potential for the indicators to have an adverse impact on people with disabilities because of something that is a consequence of the disability?
No – comments from consultation do not suggest that the indicator will have an adverse impact on people with disabilities.

Completed by lead technical analyst: Gavin Flatt

Date 30/03/2017

Approved by NICE quality assurance lead: Nicola Greenway

Date 06/04/2017