

**University of Birmingham and University of York Health Economics
Consortium (NCCID)
Development feedback report on piloted indicators**

QOF indicator area: Diabetes prevention

Pilot period: 1st October 2016 – 28th February 2017

Potential output: Recommendations for NICE menu

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Summary of recommendations

Indicator

1. The contractor establishes and maintains a register of patients with a diagnosis of non-diabetic hyperglycaemia.

Acceptability recommendation:

Band 2: 60-69% of practices support inclusion.

Implementation recommendation:

Band 2: minor problems identified during piloting or anticipated to arise in wider implementation.

Cost effectiveness recommendation:

See summary report.

Issues to consider:

Issue	Detail	Mitigating activity
Register construction	We piloted register construction using codes for non-diabetic hyperglycaemia, pre-diabetes, impaired glucose tolerance, HbA1c and Fasting Plasma Glucose readings. Is the committee content with this approach?	

Indicator

2. The percentage of patients, 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.

Acceptability recommendation:

Band 4: <50% of practices support inclusion.

Implementation recommendation:

Band 2: minor problems identified during piloting or anticipated to arise on wider implementation.

Cost effectiveness recommendation:

See summary report.

Issues to consider:

Issue	Detail	Mitigating activity
What is a diabetes prevention programme?	For the purposes of piloting we only included referrals to the Healthier You: NHS Diabetes Prevention Programme. Practices expressed some concern regarding uptake of this and favoured the option of giving advice in the practice.	
Cross year issues	Does the indicator need to account for patients diagnosed in the last 3 months of the QOF year?	In the pilot we did not support this. Without an adjustment patients diagnosed in the last 3 months of the year would be exception reported if they had not been referred to the prevention programme. Their records would not be examined in the following year to see if they were referred at a later date. As they would then be essentially 'lost' from the assessment of quality we usually recommend adjusting the business rules to account for this.
Exception reporting	Do we need to add an exception for Diabetes structured education programme not available like we do for current indicator referring patients for diabetes education?	Only codes available related to structured education for people with diabetes. New more specific codes will be required.
Timeframe for referral	Does the referral need to take place within a certain timeframe of the diagnosis?	In the pilot the Business Rules looked for a referral on or after the date of diagnosis but did not have any other timeframe on. If the indicator was to go forward to be used in QOF then would this need revisiting or would anytime on or after initial diagnosis suffice as may be limitations around central purchasing decisions?

Indicator

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

Acceptability recommendation:

Band 2: 60-69% of practices support inclusion.

Implementation recommendation:

Band 2: minor problems identified during piloting or anticipated to arise in wider implementation.

Cost effectiveness recommendation:

See summary report.

Issues to consider:

Issue	Detail	Mitigating activity
Recent diagnoses	The business rules exclude patients diagnosed in the last 3 months of the QOF year.	Given that this indicator measures an annual review post-diagnosis, should this time period be extended to diagnoses in the preceding 12 months?
Exception reporting	We did not include codes for blood test refused	These will need to be added to the business rule for widespread implementation.

Background

As part of the NICE-managed Quality and Outcomes Framework (QOF) process, all clinical and health improvement indicators are piloted, using an agreed methodology, in a representative sample of GP practices across England, Scotland, Wales and Northern Ireland.

The aim of piloting is to test whether indicators work in practice, have any unintended consequences and are fit for purpose.

Due to the current limited availability of the National Diabetes Prevention Programme in England we undertook some additional piloting in GP practices in an early adopter site. A total of four GP practices were recruited. They piloted the proposed indicators for three months between December 2016 – February 2017. As part of this work we also undertook a series of focus groups with patients with non-diabetic hyperglycaemia to seek their views on the suitability of the proposed quality measures. Results for these additional pilot sites are reported separately to the main pilot sites at the end of the indicator acceptability section.

Practice recruitment

Number of practices recruited:	29
Number of practices dropping out:	2
Number of practices unable to interview:	0
Number of practices interviewed:	27

[26 GPs, 6 practice nurses, 9 practice managers and 1 health care assistant = 42 primary care staff]

All percentages reported have been calculated using the 29 practices recruited to the pilot as the denominator.

Piloted indicators

1. The contractor establishes and maintains a register of patients with a diagnosis of non-diabetic hyperglycaemia.
2. The percentage of patients, 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.
3. The percentage of patients with non-diabetic hyperglycaemia who have had an HbA1c test in the preceding 12 months.

Assessment of clarity, reliability, feasibility, and acceptability

Clarity

Two questions of clarity emerged during the GP focus group: firstly, the operational definition of non-diabetic hyperglycaemia and secondly, the definition of the diabetes prevention programme.

Reliability and feasibility

We were able to develop business rules to support these indicators.

Issues to be resolved prior to implementation:

Issue	Detail	Mitigating activity
Register construction	We piloted register construction using codes for non-diabetic hyperglycaemia, pre-diabetes, impaired glucose tolerance, HbA1c and Fasting Plasma Glucose readings. Is the committee content with this approach?	
Cross year issues	Does the indicator need to account for patients diagnosed in the last 3 months of the QOF year?	In the pilot we did not support this. Without an adjustment patients diagnosed in the last 3 months of the year would be exception reported if they had not been referred to the prevention programme. Their records would not be examined in the following year to see if they were referred at a later date. As they would then be essentially 'lost' from the assessment of quality we usually recommend adjusting the business rules to account for this.

Acceptability

Indicator 1: register of people with non-diabetic hyperglycaemia

Nineteen practices felt that being able to produce a register of people with non-diabetic hyperglycaemia was a marker of quality, with 18 (62.1%) of these feeling that this indicator was suitable for QOF. Five practices (17.2%) felt that this indicator should not be considered for QOF and a further three practices (10.3%) were uncertain.

“... I mean practices, really, should have been doing this for quite some time; looking at those at risk and then monitoring them and giving them advice.” (PN, Practice ID30)

“...more practices should be looking at these patients and not just saying oh you were right and then they disappear ... Whereas you can keep a register and you can then do an annual recall and get them in and make sure that they are followed up appropriately.” (GP, Practice ID25)

Patients were identified opportunistically, through the NHS Health Check and if clinicians identified them as being at increased risk of diabetes, for example, on the basis of BMI or ethnicity. Two practices expressed concern that having a QOF register, which could lead to CCGs and others calculating expected numbers of people with an elevated HbA1c could lead to screening.

“And the thing about QOF is it, it flags things up, doesn't it as well? So it might make people more aware of actually, when they are sending people for blood tests, we should also do a quick check just to see you're not at risk of diabetes.” (PN, Practice ID30)

“One of them is the NHS health check, the other is, we do use, so if the patient is having a blood test for other reasons, instead of doing just a random blood glucose which is of no use to us, we check their HbA1c.” (GP, Practice ID07)

“So, opportunistically, we screen for the people who we think are slightly higher risk. So that comes up in the NHS health checks, family history, ethnicity, past risk factors, so strong family history, previous gestational diabetes. So that's case finding. I don't think for one moment we should start screening the whole population.” (GP, Practice ID13)

A small number of practices were also concerned about the workload associated with the initial creation of the register and subsequent monitoring. Practices who were routinely coding patients with an elevated HbA1c were less concerned about the workload implications of creating a register, but did share some concerns about the workload associated with follow-up.

A small number of practices felt that this was unsuitable for QOF as having an elevated HbA1c is not a 'proper' clinical condition and that this focus shifted the boundaries of illness.

“... although, as a practice there are some reservations generally about creating the new disease and shifting boundaries in terms of creating illness...” (GP, Practice ID18)

Diabetes prevention was also felt to have a strong public health component, and reducing rates of diabetes would require societal change as well as a focus upon the activities of general practice. However, some practices felt that a refocusing of their activities upon prevention was necessary.

“I think in the past we've focused a lot more on the disease rather than preventing the disease so from that perspective it's really a welcome change in the direction I think” (GP, Practice ID04)

“I suppose really the question is, is it something relevant to general practice ... and I think we can play a role certainly, but I think it has to be within a more holistic framework in terms of strategy really...I don't think it's possible for primary care alone to tackle this...” (GP, Practice ID20)

Across all practices there were comments about the terminology used to describe having an elevated HbA1c with practices showing a preference for particular terms, such as impaired glucose tolerance and prediabetes. Non-diabetic hyperglycaemia was not commonly used, in part due to a lack of familiarity with it as a term and the relatively recent introduction of the Read code. However, these descriptive codes were not used consistently across the cohort to refer to the same levels of HbA1c. One practice raised concerns about the sensitivity and specificity of using HbA1c or fasting plasma glucose to make this diagnosis.¹

“... because it used to be impaired glucose tolerance, impaired fasting glycaemia, because we changed the way it was, you know, diagnosed.” (GP, Practice ID05)

“We've been, for some years, labelling people with raised HbA1c as being at risk of, of diabetes. We started out some years ago, calling it 'Pre-Diabetes'; then we changed to 'At Risk' and then, of course, this, this has asked us to look for non-diabetic hyperglycaemia.” (PN, Practice ID30)

“... so we've actually stopped coding people with an HbA1c of 42 or 43 as impaired glucose tolerance or pre diabetes...” (GP, Practice ID29)

“... it's slightly confusing because there's lots of different terms for non diabetic glycaemia ... pre diabetes or impaired fasting glycaemia so there's lots of you know, and that makes it difficult because there's so many different codes for it...” (GP, Practice ID25)

Indicator 2: referral to Healthier You: NHS Diabetes Prevention Programme

Pilot practices were divided as to whether this was a suitable indicator of quality in general practice. Thirteen practices (44.8%) felt that this indicator was suitable for QOF, although three expressed the view that referral should not be limited only to the Healthier You programme but should also include local lifestyle advice schemes. A similar number, 11 practices (37.9%), did not feel that this was either a marker of quality or suitable for QOF and one was unsure (3.5%).

Across the pilot cohort access to the programme was limited and it was felt that this should be available in all areas before it was introduced into QOF. Practices also expressed some doubts about the utility of a centralised programme and, whilst prevention was generally viewed as a positive activity, doubts were expressed about its potential effectiveness. Practices were unconvinced that

¹ Barry et al. Efficacy and effectiveness of screen and treat policies in prevention of type 2 diabetes: systematic review and meta-analysis of screening tests and interventions. *BMJ* 2017; 356
doi:<https://doi.org/10.1136/bmj.i6538>.

patients would commit to a lengthy programme, travel potentially long distances to a centralised delivery point. A preference was expressed for local, GP based delivery of interventions.

“we haven’t had any difficulties but in terms of the engagement, the outcome and whether transport’s going to be an issue for people...” (GP, Practice ID04)

“If we could offer something that was in practice and we find that patients tend to welcome that more than having it in a clinic in [city name] where some patients have to catch two buses in order to get in and things, so...” (GP, Practice ID29)

“The ones that are a bit more difficult to engage are the ones you’re going to struggle with and those are the ones who are more likely going to develop diabetes and they’re the ones that are probably aren’t going to engage with a 13 week ...” (GP, Practice ID25)

Given their concerns about take-up of the intervention, practices felt that the indicator should be ‘offered referral’ rather than ‘referred’. Within the pilot business rules patients who declined referral were exception reported.

Indicator 3: HbA1c in the preceding 12 months

Twenty practices felt that this was a marker of quality in general practice, with 19 of these (65.5%) supportive of it being considered for QOF. Five practices (17.2%) did not think this should be considered for QOF and two practices (6.9%) were uncertain. Two practices reported being unable to request HbA1c or fasting plasma glucose in patients without a diagnosis of diabetes.

This was generally regarded as a good thing to do both to keep people engaged in changing their lifestyle and to prompt early identification of diabetes. There was also an acknowledgement that these people may be forgotten. However, some practices were unconvinced of the need for HbA1c to be repeated annually as opposed to a longer a recall timeframe.

“Well, you – you’re doing the test because you say the data is that these – a significant proportion of these people will go on and become diabetic, with a view to diagnosing the fact they’ve become diabetic earlier.” (GP, Practice ID29)

“...this group was often forgotten five or six years ago and then we were seeing that the patients we were diagnosing with diabetes, often they were more symptomatic, they were diagnosed with HbA1c of 10, 11, 9, now the patients we are diagnosing with diabetes, their HbA1c is 6.5, 6.6 so at a very early stage we’re diagnosing diabetes, which is an advantage...” (GP, Practice ID07)

“...so really do we want to be re-checking that every year, is it not satisfactory to be checking it every five years because otherwise you create a hell of a lot of work with people, basically these people are borderline...” (GP, Practice ID16)

“To be honest, the reason we’re doing it, and I suppose the reason I justify it, thinking about it again, is that you don’t want these people to run HbA1cs of 9% for sort of five years before you pick them up. So if you miss a year before you then get them back again and they’ve converted, they won’t have done themselves any long-term harm.” (GP, Practice ID13)

Many practices were already attempting to follow-up these patients on a more opportunistic basis. Whilst it was felt that the QOF call/recall structures could potentially make this more efficient practices were concerned about the additional workload this could create. In some practices the numbers of people with non-diabetic hyperglycaemia exceeded those with diabetes.

“...once again a huge amount of work...” (GP, Practice ID07)

“We’ve got enough of our known diabetics who aren’t getting their HbA1c testing done anyway, so we’ve got another group of patients who are going we’re going to be chasing down. It boils down to manpower.” (GP, Practice ID10)

“So, great, but that’s 169 of them; I’m not sure I’m going to be doing 169 new blood tests every single year, calling them in and all the rest of it. I just don’t think that’s going to happen.” (GP, Practice ID22)

Acceptability in early adopter sites

We also piloted these indicators in four practices in a Healthier You: NHS Diabetes Prevention Programme early adopter site. The benefits and concerns noted by these practices were similar to those identified by the wider pilot cohort.

Indicator 1: register

All four practices (100%) thought that being able to create a register was a marker of quality (so long as other indicators were associated with it) and suitable for consideration for QOF. As with the wider pilot cohort, patients were identified in a variety of ways. Mainly opportunistically through NHS Health Checks or when identified as being at increased risk, for example, patients with a raised BMI.

These practices identified that creating a register could be a cause of additional workload but this did not seem to be a significant issue. This may be due in part to the additional support they received from the CCG as a result of being an early adopter site. The CCG supported these practices by running searches for patients known to have an elevated HbA1c and identifying those who required additional testing to confirm eligibility for the prevention programme.

Indicator 2: referral to Healthier You: NHS Diabetes Prevention Programme

Again, all four practices (100%) felt that this was a marker of quality and suitable for consideration for QOF. As a group they were more positive about the potential benefits of a diabetes prevention programme but they had yet to receive much feedback from the patients they had referred.

However, they also shared some concerns raised by the wider pilot cohort. Namely, patient engagement with the programme and whether they would commit to the time required. One

practice raised concerns about the management of patients with a normal BMI who undertook regular exercise. They felt that referral to the programme was unlikely to be beneficial for this group as whilst they required ongoing monitoring they did not need to make significant lifestyle changes.

“...And the other difficulty is that you know some of the patients I’ve seen who are, have come out in that range they’re fit, you know they’re not overweight, they’re healthy eaters, they exercise regularly, no family history of diabetes and actually I look at them and I think you don’t need, you know you don’t really need to change anything because actually the lifestyle changes and stuff that we’ve been talking about aren’t applicable to you...” (GP, Practice ID33)

Indicator 3: HbA1c in the preceding 12 months

Again all practices (100%) felt that this should be considered for inclusion in QOF. This was for similar reasons as the wider pilot practices. In common with the wider pilot practices they were only starting to move away from opportunistic review to more formal call/ recall systems.

Patient views of the indicators

We undertook 6 focus groups comprising of 55 people with non-diabetic hyperglycaemia recruited from the GP pilot practices in the early adopter site, to seek their views on the proposed indicators. As with other studies which have sought patient views on incentives they were surprised that these were felt necessary as they thought that doctors should be doing this anyway, although the majority thought that the indicators were sensible. A small number of participants felt that general practice should be incentivised for achieving outcomes, which in this case was described as reducing the numbers of people going on to develop diabetes.

One area of concern was the focus upon the national diabetes prevention programme. Participants had some experience of this and they felt that advice and support being limited to this programme was too restrictive. Some participants who were in full time work, or with limited access to transport, had chosen not to attend the programme when it was offered and, as a consequence, felt that they had received little support. Some participants also did not want to attend a group class.

Assessment of implementation

Assessment of piloting achievement

Indicator 1: register

Prevalence of NDH across the main pilot cohort was 2.5% at the final data extraction. The average number of patients at a practice level was 217 (range 52 – 831). Within the early adopter site the average number of patients per practice was 206 (range 139-289).

To be included on the register patients needed to be coded with either non-diabetic hyperglycaemia, pre-diabetes or impaired glucose tolerance. We also modelled identification using two HbA1c recordings of 42-47 mol/L inclusive within 93 days of each other or two fasting plasma glucose levels of 5.5-6.9 mol/L within the same time frame. Practices tended to demonstrate a preference for one

code cluster. Restricting the eligible codes could result in significant recoding at a practice level however, there is the potential that the descriptive codes can change in meaning over time as diagnostic thresholds change. NICE are currently reviewing the guideline underpinning this indicator set and there is the possibility that the thresholds for diagnosis may change as a result of this. However, generating the register on the basis of HbA1c or fasting plasma glucose levels is more technically challenging, especially where subsequent indicators rely upon specific events such as earliest date of diagnosis. We did not include the 'at risk of diabetes code' as this is used in practice to indicate potential increased risk e.g. family history, gestational diabetes, increased BMI but not necessarily an elevated HbA1c.

Indicator 2: referral

% patients referred to Diabetes Prevention Programme	Baseline	Final
Number of practices uploading	14	14
Practice population (from NHAIS)	118341	119968
Register	2852	3037
Excluded		
Rule 1: diagnosis > 12months ago at baseline and >5 months ago at final extract	2194	2456
Exception reported		
Rule 3: Referral declined	0	2
Rule 4: Recent registration	9	13
Rule 5: Recent diagnosis	114	143
Total exceptions	2317	2614
Exceptions as a % of eligible population	81.24	86.07
Denominator	535	423
Numerator	0	1
Numerator as a percentage of denominator	0	0.24

The Diabetes Prevention Programme was unavailable in most of the main pilot areas; hence the low levels of achievement. The majority of exception reporting was due to patients being labelled as NDH outside the eligible timeframe for referral. In the early adopter site achievement for referral to the programme ranged from 0 – 73.3% depending upon the duration of their involvement with the programme.

Indicator 3: annual HbA1c

% patients referred to Diabetes Prevention Programme	Baseline	Final
Number of practices uploading	14	14
Practice population (from NHAIS)	118341	119968
Register	2852	3037
Exception reported		
Rule 4: Recent registration	9	18
Rule 5: Recent diagnosis	69	74
Total exceptions	78	92
Exceptions as a % of eligible population	2.73	3.03
Denominator	2774	2945
Numerator	1580	968
Numerator as a percentage of denominator	56.96	32.87

As with the gestational diabetes indicator, it is likely that achievement has been underestimated due to a coding issue which did not become apparent until the end of piloting. The pilot business rules were missing a commonly used code for HbA1c testing. Practice achievement in the main pilot sites ranged from 10-70% at baseline (12 month period) and 6-50% at the final extract (5 month time period). Baseline results from the early adopter sites were slightly better ranging from 39.3% - 56.1%.

Changes in practice organisation

So long as practices are coding people with non-diabetic hyperglycaemia then register creation was not viewed as problematic and this could then be used to support call/ recall for the annual HbA1c test.

Resource utilisation and costs

Although practices are undertaking some of this monitoring already as achievement improves it is likely that there will be increased costs due to additional blood tests and practice associated costs of proactively chasing people for monitoring.

Barriers to implementation

The main barrier to implementation is the availability of the National Diabetes Prevention Programme. This is currently being rolled out across England and is expected to be available in all areas by 2020.

Practices were also concerned about the additional workload associated with needing to perform an HbA1c on, what could be a large number of patients. Some practices were unconvinced that this was required.

Assessment of exception reporting

During the pilot, the largest driver of exception reporting was patients being labelled with non-diabetic hyperglycaemia outside of the timeframe for referral to the prevention programme. Exception reporting for other reasons was low. This could reasonably be expected to increase on widespread implementation and with addition of HbA1c refused codes to the business rules for indicator 3.

Assessment of potential unintended consequences

No unintended consequences were observed during the pilot.

Assessment of overlap with and/or impact on existing QOF indicators

Whilst there is no overlap with existing QOF indicators, there is overlap with the indicator focusing upon HbA1c measurement in patients with a history of gestational diabetes piloted at the same time.

Suggested amendments to indicator wording

None.

Appendix A: Practice recruitment

We planned to recruit 34 practices in England and 2 in each of the Devolved Administrations. English practices were to be representative in terms of practice list size, deprivation and clinical QOF score. Given the limited variability in clinical QOF score we excluded practices with a score of $\leq 10^{\text{th}}$ centile. Practice list size and IMD scores were divided into tertiles and a 3x3 matrix created with target recruitment numbers for each cell. These are detailed in the table below.

	List size		
IMD Score	Low	Medium	High
Low	3	4	5
Medium	3	4	4
High	4	4	3

As previously presented to the Committee, practice recruitment has been extremely challenging. At the beginning of this pilot we had recruited 28 practices in England and 3 in the Devolved Administrations (2 in Northern Ireland, 1 in Scotland). Practice recruitment by strata is shown in the table below with cells in bold where we failed to meet target numbers. We also over recruited in one strata which is shown by the numbers in the table. Two practices in England withdrew from the pilot prior to it starting reducing the total numbers of pilot practices to 26 in England, 2 in Northern Ireland and 1 in Scotland.

	List size		
IMD Score	Low	Medium	High
Low	2/3	3/4	1/5
Medium	3/3	4/4	1/4
High	5/4	4/4	3/3

Appendix B: Indicator development

Following the June 2016 Advisory Committee meeting the NCCID was asked to develop new indicators to support the roll out of the diabetes prevention programme in England..

GP focus group

A focus group to discuss potential indicators was held on 20th July 2016 where all potential indicators were discussed. Focus group attendees were volunteers recruited via our database of GPs who had responded to previous invitations. From the volunteers we purposively selected 15 GPs to attend the focus group to try to ensure a balance of men and women, representation from minority ethnic groups and a range of ages.

Of those invited, 14 attended the meeting. Nine (60%) were male. Approximately one third of the participants described themselves as being of white ethnicity (n=5). Participants were reimbursed £250 for their attendance.

Anneka Patel and Shaun Rowark attended on behalf of NICE. Gemma Ramsey and Ross Ambler attended on behalf of NHS Digital.

Three indicators were presented: a register, referral to an approved intensive lifestyle intervention and annual follow-up using HbA1c.

Discussion of this indicator set focused upon the methods used to identify people with non-diabetic hyperglycaemia and the appropriateness of the NHS DPP approved lifestyle interventions for all patients. The consensus was that the indicator should not be restricted to a single programme. There were also perceptions that achievement would be limited, not by practitioner effort, but by service availability and that this may make them unachievable. This could have the effect of demoralising GPs. There was also debate as to whether the indicator wording should be 'referred' or 'offered referral'.

Participants queried why the register was not being populated using recorded HbA1c values, highlighting a need for this to be addressed in piloting guidance.

Three indicators were progressed to piloting.

Indicator wording as piloted

1. The practice establishes and maintains a register of all patients with a diagnosis of non-diabetic hyperglycaemia.
2. The percentage of patients, 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.
3. The percentage of patients with non-diabetic hyperglycaemia who have had an HbA1c test in the preceding 12 months.

Appendix C: Acceptability and Implementation recommendations

Acceptability recommendations

One of the following recommendations is made based upon reported acceptability of the indicator to pilot practices.

Band 1: $\geq 70\%$ of practices support inclusion

Band 2: 60-69% of practices support inclusion

Band 3: 50-59% of practice support inclusion

Band 4: $< 50\%$ of practices support inclusion.

Implementation recommendations

One of the following recommendations is made based upon an assessment of issues or barriers to implementation reported during piloting.

Band 1: no problems identified during piloting or anticipated to arise. Indicator terms precisely defined.

Band 2: minor problems identified during piloting or anticipated to arise in wider implementation. Problems resolvable prior to implementation through either 1) an amendment to indicator wording, 2) an amendment to the business rules and/or 3) by giving further clarification of indicator terms in associated guidance.

Band 3: major problems identified during piloting or anticipated in wider implementation. Possibly resolvable through the actions described in band 2 but indicator requires further development work and/or piloting.

Band 4: major problems identified during piloting. Not immediately resolvable. Indicator not recommended for wider implementation.