Indicators for the NICE menu for the QOF

**Indicator area:** Chronic kidney disease

**Indicator:** NM109

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The percentage of patients on the CKD register whose notes have a record of a urine albumin:creatinine ratio (or protein:creatinine ratio) test in the preceding 12 months.

**Please note:** NICE inherited this indicator when it became responsible for managing the process of developing and maintaining QOF indicators in 2009.

**Introduction**

Chronic kidney disease (CKD) describes abnormal kidney function and/or structure. CKD is frequently unrecognised and often exists together with other conditions, such as cardiovascular disease and diabetes. CKD is usually asymptomatic or lacks specific symptoms, so it is often not diagnosed or diagnosed at an advanced stage. CKD is common: the full NICE guideline suggests an overall prevalence of 13%\(^1\). The risk of developing CKD increases with age.

Protein or albumin excretion in urine (proteinuria or albuminuria) is a marker of kidney damage, which can be measured using a urine albumin:creatinine ratio (ACR) or protein:creatinine ratio (PCR) test.

**Rationale**

This indicator measures the percentage of people with CKD who have an annual urine ACR or PCR test. The aim is to ensure monitoring of the severity of kidney damage in people with CKD.

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\(^1\) National Institute for Health and Care Excellence (2014) [CKD](http://www.nice.org.uk/guidance/cg182) NICE guideline CG182
Good evidence shows proteinuria is associated with adverse outcomes and that proteinuria measurement enables appropriate management of CKD. The NICE guideline for chronic kidney disease recommends using ACR in preference to PCR, because of its greater sensitivity. PCR is only recommended as an alternative to ACR to monitor high levels of proteinuria (ACR $\geq 70$ mg/mmol), but not for people with diabetes. The guideline states that the frequency of ACR monitoring should be agreed with the person, but based on the severity of CKD. Recommended frequencies of monitoring range from once a year in people with CKD class G3a (A1–A2), to 4 or more times a year in people with CKD class G5. For the purposes of a primary care indicator, annual ACR or PCR testing is considered appropriate, because the CKD register includes people with CKD of all classes G3a–G5.

**Source guidance and recommendations**

- [Chronic kidney disease](#) (2014) NICE guideline CG182
  - Recommendation 1.1.18: To detect and identify proteinuria, use urine ACR in preference to protein:creatinine ratio (PCR), because it has greater sensitivity than PCR for low levels of proteinuria. For quantification and monitoring of levels of proteinuria of ACR 70 mg/mmol or more, PCR can be used as an alternative. ACR is the recommended method for people with diabetes.
  - Recommendation 1.3.1: Agree the frequency of monitoring (eGFR creatinine and ACR) with the person with, or at risk of, CKD; bear in mind that CKD is not progressive in many people.
  - Recommendation 1.3.2: Use table 2 to guide the frequency of GFR monitoring for people with, or at risk of, CKD, but tailor it to the person according to:
    - the underlying cause of CKD
    - past patterns of eGFR and ACR (but be aware that CKD progression is often non-linear)
    - comorbidities, especially heart failure
    - changes to their treatment (such as renin–angiotensin–aldosterone system [RAAS] antagonists, NSAIDs and diuretics)
    - intercurrent illness
whether they have chosen conservative management of CKD.

Further information

This is NICE indicator guidance for QOF, which is part of the NICE menu of indicators. This document does not represent formal NICE guidance. The NICE menu of indicators for QOF is available online at:

http://www.nice.org.uk/standards-and-indicators/qofindicators