NICE Indicator Programme

Consultation on proposed changes and additions to existing NICE menu indicators used in the QOF and new NICE indicators

Consultation dates: 17/04/2019 to 16/05/2019

This consultation presents amended and new indicators with a focus on personalised care, addressing over- and under-treatment, and ensuring the best outcomes for patients. New NICE indicators included in this document are presented in three sections:

- **Proposed changes and additions to existing NICE menu QOF indicators used in the QOF**
    - Asthma
    - COPD
    - Heart Failure
- **New indicators for general practice**
    - Multimorbidity and frailty
    - Familial hypercholesterolemia (FH)
    - Alcohol
- **New indicators - local authority**
    - HIV testing in areas with high or extremely high prevalence

We welcome comments from stakeholders. Feedback from this consultation will be reviewed by the NICE Indicator Advisory Committee in June 2019.

The proposed indicators may change following consultation.

If you have any questions about this consultation, please contact the NICE Indicator Team (indicators@nice.org.uk).

QOF forms part of the GMS contract, and as such proposed changes to QOF are subject to negotiations between NHS England and the BMA's General Practitioners Committee.

Contents

Introduction

The 2019/20 GP Contract outlined plans for an ongoing programme of indicator review aimed at increasing the likelihood of improved patient outcomes, decreasing the likelihood of harm from overtreatment and improving the personalisation of care.

This consultation paper includes:

- Proposals for respiratory indicators focusing on accurate diagnosis. Given the lifelong implications of misdiagnosis, potential risk of adverse effects from unnecessary treatment and the development of more robust diagnostic pathways in NICE guidance, these indicators can help support accurate diagnosis and inform appropriate treatment.
- Proposals for respiratory indicators to include exacerbation history to help guide future management and improve personalisation of care.
- Proposals for heart failure indicators to support optimisation of pharmacological treatment.
- New indicators for multimorbidity / frailty, familial hypercholesterolaemia (FH) and alcohol. A number of these may be suitable for consideration for inclusion in the QOF.
- New HIV testing indicators to help support local implementation of NICE guidance in the small number of local authorities (79/325) with a high or extremely high prevalence of diagnosed HIV[1]. These two indicators are designed for these specific geographical locations and are not suitable for consideration for inclusion in the QOF.

[1] In England 79 of 325 local authorities have a high diagnosed prevalence (>2 per 1,000 population) of these 19 have an extremely high prevalence (>5 per 1,000 population) – Source: PHE 2018

How we develop indicators and the purpose of the consultation

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

How to submit your comments

Please send your comments using the form available on the NICE website to indicators@nice.org.uk by 5pm on Wednesday 16 May 2019.

Proposed changes to existing NICE menu indicators used in the QOF

Asthma

Asthma – Maintaining a register of patients (5 years and older)	
Proposed new indicator	**IND63**: The contractor establishes and maintains a register of patients with asthma aged 5 or over.
Existing QOF indicator	**AST001**: The contractor establishes and maintains a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the preceding 12 months.
Rationale for the new indicator	The current QOF asthma register does not have a lower age range, it includes children under 5 years of age. The new indicator recognises that it can be difficult to confirm a diagnosis of asthma in children under 5 years of age (NICE, NG80). The lower age for the indicator has been added to reflect uncertainty in diagnosis and to reduce the risk of overdiagnosis / overtreatment. In addition, the current register excludes people who have been prescribed no asthma-related drugs in the preceding 12 months. Originally intended as a proxy for people in whom a true diagnosis is unlikely, the development of robust diagnostic pathways in NICE provides a more accurate method of confirming diagnosis. An incorrect diagnosis of asthma may result in life long implications, and unnecessary treatment with the potential risk of adverse effects (NICE, 2015).
Evidence base	Asthma: diagnosis, monitoring and chronic asthma management (2017) NICE guideline NG80

Asthma – Objective tests to support diagnosis	
Proposed new indicator	**IND64**: The percentage of patients with asthma on the register (*date of implementation*) with a record of an objective test of FeNO, spirometry, reversibility or variability between 3 months before or 3 months after diagnosis.
Existing QOF indicator	**AST002**: The percentage of patients aged 8 or over with asthma (diagnosed on or after 1 April 2006), on the register, with measures of variability or reversibility recorded between 3 months before or any time after diagnosis. NICE menu ID: NM101
Rationale for the new indicator	Misdiagnosis of asthma can have lifelong implications and result in inappropriate treatment with the risk of adverse effects. It can also mean alternative underlying conditions are not diagnosed. Using objective tests to confirm diagnosis can improve the accuracy of a diagnosis and reduce incidences of patients receiving inappropriate care. Results of testing should inform subsequent treatment for people with asthma and lead to improved health and wellbeing. This indicator requires a record of an objective test: FeNO or spirometry or reversibility or variability.
Evidence base	Asthma: diagnosis, monitoring and chronic asthma management (2017) NICE guideline NG80, recommendations 1.3, 1.4 Asthma (2013) NICE Quality Standard QS25 Quality Statement 1

Asthma – Patients who have had an asthma review	
Proposed indicator	**IND65**: The percentage of patients with asthma on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using a validated asthma control questionnaire (including assessment of short acting beta agonist use), a recording of the number of exacerbations and a written personalised action plan.
Existing QOF indicator	**AST003**: The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. NICE menu ID: NM23
Rationale for the new indicator	Published evidence suggests that both people with asthma and clinicians tend to underestimate asthma severity and overestimate asthma control when simply asking a patient 'How is your asthma?'. Asthma control questionnaires assess asthma related quality of life, with evidence (NICE NG80) that validated questionnaire can lead to reduced exacerbations. Assessing use of short acting beta agonists and recording exacerbations can help identify people with asthma who are at increased risk of poor outcomes. People with asthma can use information and advice from these reviews to inform their self-management, maximising their future health.
Evidence base	Asthma: diagnosis, monitoring and chronic asthma management (2017) NICE guideline NG80, recommendations 1.10.1, 1.10.2, 1.14.2 Asthma (2013) NICE Quality Standard QS25 Quality Statements 2, 3 British guideline on the management of asthma (2016) SIGN guideline, section 1.4.

Asthma – Patients record of smoking status	
Proposed indicator	**IND66**: The percentage of patients with asthma on the register aged 19 or under, in whom there is a record of smoking status (active or passive) in the preceding 12 months.
Existing QOF indicator	**AST004**: The percentage of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, in whom there is a record of smoking status in the preceding 12 months. NICE menu ID: NM102
Rationale for the new indicator	Asthma and tobacco smoke interact to cause more severe symptoms, these symptoms include accelerated decline in lung function, and impaired short-term therapeutic response to corticosteroids (Thomson, et al. 2004). In addition, exposure to environmental tobacco smoke results in an increase in the frequency of emergency care attendances for the treatment of acute asthma exacerbations (Chilmonczyk et al. 1993) • The available data for children and young people aged between 11 and 15 years (NHS Digital, 2017a) report that 7% are regular or occasional smokers, these data are for all children and young people rather than those with asthma. The prevalence of smoking increases with age, from less than 1% of 12-year olds to 15% of 15-year olds. • In addition, children and young people are exposed to 'second hand' smoke in their home or in someone else's home with 14% of 11 to 15 year old's being exposed to secondhand smoke "every day or most days" (NHS Digital, 2017a). Over the previous 12-month period 62% reported being exposed to second hand smoke in their home, someone else's home or in car. This indicator aims to encourage general practice to ask children and young people aged 5 to 19 years with asthma about their exposure to tobacco and encourage smoking cessation advice.
Evidence base	Asthma: diagnosis, monitoring and chronic asthma management (2017) NICE guideline NG80, recommendations 1.5.1

COPD

COPD – Objective testing to support diagnosis	
Proposed indicator	**IND67:** The contractor establishes and maintains a register of: 1. Patients with a clinical diagnosis of COPD before (*date of implementation*), and 2. Patients with a clinical diagnosis of COPD on or after (*date of implementation*) whose diagnosis has been confirmed by a quality assured post bronchodilator spirometry FEV1/FVC ratio below 0.7 between 3 months before or 3 months after diagnosis.
Existing QOF indicators	**COPD001**: The contractor establishes and maintains a register of patients with COPD **COPD002**: The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering on to the register. NICE menu ID: NM103.
Rationale for the new indicator	Demonstration of the presence of airflow obstruction is critical to making a diagnosis of COPD, with NICE guidance (NG115) recommending spirometry. For people with a clinical diagnosis on or after 1st April 2020 the new indicator incentivises a diagnosis of COPD supported by objective testing 3 months before or 3 months after initial diagnosis. The new indicator is prospective only being applicable to new cases of COPD. Evidence from Wales (Fisk et al. 2019) highlights that 25% of people on the COPD register had spirometry incompatible with COPD, similar data for England would be expected. Linking diagnosis and objective testing to entry onto the QOF COPD disease register aims to contribute towards a reduction in both misdiagnosis and the risk of overtreatment in people with COPD.
Indicator purpose	To confirm the diagnosis of COPD and contribute towards a reduction in both misdiagnosis and overtreatment.
Evidence base	Chronic obstructive pulmonary disease in over 16s: diagnosis and management (2018) NICE guideline NG115, recommendations 1.1.4, 1.1.5, Table 4 Gradation of severity of airflow obstruction

COPD – Annual review including recording of exacerbations	
Proposed indicator	**IND68**: The percentage of patients with COPD on the register, who have had a review in the preceding 12 months, including a record of the number of exacerbations and an assessment of breathlessness using the Medical Research Council dyspnoea scale.
Existing QOF indicator	**COPD003**: The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months. NICE menu ID: NM104.
Rationale for the new indicator	Exacerbations affect morbidity in people with COPD, with evidence that people with COPD at the highest risk of exacerbations can be identified by exploring medical history for the presence of prior exacerbations (Mullerova et al. 2014). Evidence from the UK (Quint et al. 2011) reports that people with COPD remember the number of exacerbations that they have experienced, with the authors noting that patient recall is sufficiently robust to inform stratification to identify frequent and infrequent exacerbator groups for subsequent years. Understanding the frequency of exacerbations can help when creating personalised management plans, identifying triggers and avoiding future exacerbations.
Indicator purpose	The new indicator updates the current QOF indicator to include the recording of the number of exacerbations
Evidence base	Chronic obstructive pulmonary disease in over 16s: diagnosis and management (2018) NICE guideline NG115, recommendation 1.1.3

Heart failure

Heart failure – confirmed diagnosis	
Proposed indicator	**IND69**: The percentage of patients with a diagnosis of heart failure (diagnosed on – *date of implementation*) which has been confirmed by an echocardiogram or by specialist assessment between 3 months before or 3 months after entering on to the register.
Existing QOF indicator	**HF002**: The percentage of patients with a diagnosis of heart failure (diagnosed on or after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment 3 months before or 12 months after entering on to the register NICE menu ID: NM116.
Rationale for the new indicator	Earlier diagnosis in primary care allows treatment initiation, potentially avoids emergency admission to hospital, and improves patient outcomes (Taylor et al. 2019). The NHS Long term Plan (NHS England 2019) promises greater access to echocardiography to improve the early detection of heart failure. The new indicator reduces the timeframe for confirming diagnosis after entry on the register to help ensure that people with heart failure receive the right diagnosis and receive timely treatment that can control symptoms, improve quality of life and help reduce premature mortality.
Evidence base	Chronic heart failure in adults (2018) NICE guideline NG106, recommendations 1.2.3 and 1.2.4

Heart failure – pharmacological treatment	
Proposed indicator	**IND70**: The percentage of patients with a current diagnosis of heart due to left ventricular systolic dysfunction, who are currently treated with an ACE-I or ARB.
Existing QOF indicator	**HF003**: In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB. NICE menu ID: NM89
Rationale for the new indicator	There is good evidence (NICE NG106) that prescribing ACE-I/ARB as well as beta-blockers for heart failure with reduced ejection fraction below 40%, can improve symptoms, reduce hospitalisation rate and improve survival. The latest NICE guideline (NG106) defines heart failure with reduced ejection fraction (HFREF) as heart failure characterised by a left ventricular ejection fraction (LVEF) of less than 40%. The new indicator will support the recording of LVEF through including the LVEF recording in the indicator denominator code clusters. This indicator focusses on ACE-I or ARBs only to help ensure the denominator size is large enough at practice level to not be subject to random variation in achievement.
Evidence base	Chronic heart failure in adults (2018) NICE guideline NG106, recommendation 1.4.1.

Heart failure – pharmacological treatment	
Proposed indicator	**IND71**: The percentage of patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, who are currently treated with a beta-blocker licensed for heart failure.
Existing QOF indicator	**HF004**: In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction who are currently treated with an ACE-I or ARB, the percentage of patients who are additionally currently treated with a beta-blocker licensed for heart failure. NICE menu ID: NM90
Rationale for the new indicator	There is good evidence (NICE NG106) that prescribing ACE-I/ARB as well as beta-blockers for heart failure with reduced ejection fraction below 40%, can improve symptoms, reduce hospitalisation rate and improve survival. The latest NICE guideline (NG106) defines heart failure with reduced ejection fraction (HFREF) as heart failure characterised by a left ventricular ejection fraction (LVEF) of less than 40%. The new indicator will support the recording of LVEF through including the LVEF recording in the indicator denominator code clusters. This indicator focusses on beta-blockers only to help ensure the denominator size is large enough at practice level to not be subject to random variation in achievement.
Evidence base	Chronic heart failure in adults (2018) NICE guideline NG106, recommendation 1.4.1

New indicator for heart failure

Heart failure - Clinical review	
Proposed indicator	**IND72**: The percentage of patients with heart failure, on the register, who had a review, undertaken by a healthcare professional, including an assessment of functional capacity (using the New York Heart Association classification) and a review of medication in the preceding 12 months
Rationale for the new indicator	The New York Heart Association classification allows people with heart failure a method of classifying and monitoring their condition, this classification can be used to guide future treatment and care. The NICE guideline for heart failure (NG106) highlights the importance of medicines optimisation for people receiving treatment. Taylor et al. (2019) found that while there have been gradual improvements in survival rates, the outlook for people after a new diagnosis remains poor. Conrad et al (2018) highlighted improvements in the initiation of pharmacological treatment but noted opportunities for improvement in medicines optimisation.
Evidence base	Chronic heart failure in adults (2018) NICE guideline NG106, recommendations 1.7.1 and 1.7.3.

New indicators for general practice

Multimorbidity and frailty

Multimorbidity register	
Proposed new indicator	**IND1**: The practice can produce a register of people with multimorbidity who would benefit from a tailored approach to care.
Background / Rationale for piloting and consulting on the new indicator	The NICE multimorbidity guideline (NG56) defines multimorbidity as two or more long-term health conditions that coexist independently in the same individual. NICE has developed a pragmatic definition of multimorbidity for the register using the presence of 4 or more condition categories which reflects an appraisal of international evidence, analysis of primary care data, and discussions with national academic, GP and clinical leads alongside the NICE Indicator Advisory Committee. The indicator makes use of existing data to allow a register of people with multiple conditions to be constructed. For pragmatic reasons the register focuses on people with conditions in four or more of the categories. The conditions are based upon a cross-sectional study on the distribution of multimorbidity (Barnett et al. 2012) The register will support interventions that lead to improvement in health-related quality of life, care related decisions and patient safety and reduce adverse outcomes such as unplanned admissions.
Evidence base	NICE guideline NG56 (2016) Multimorbidity: clinical assessment and management. Recommendations 1.1.1, 1.3.1. NICE quality standard QS153 (2017) Multimorbidity. Statement 1.

Multimorbidity register – people with conditions in 4 or more categories	
Category	**Condition**
Cancer	Cancer
Chronic pain	Painful condition[2]
Circulatory conditions	Coronary heart disease Atrial fibrillation or atrial flutter Heart failure Hypertension Stroke or TIA Peripheral vascular disease
Diabetes	Diabetes
Digestive system conditions	Currently treated constipation[3] Diverticular disease of intestine Inflammatory bowel disease Chronic liver disease
Learning disability	Learning disability
Mental health	Anorexia or Bulimia Anxiety & other neurotic, stress related and somatoform disorders Dementia (including Alzheimer's) Depression Schizophrenia and related non-organic psychosis Bipolar disorder Alcohol problems Psychoactive substance misuse
Musculoskeletal conditions	Rheumatoid arthritis Other inflammatory polyarthropathies Systemic connective tissue disorders
Neurological conditions	Currently treated epilepsy Multiple sclerosis Parkinson's (of any cause)
Renal conditions	Chronic kidney disease
Respiratory conditions	Currently treated asthma COPD Bronchiectasis

[2] Defined by the presence of 4 or more prescription only medicine analgesic prescriptions or 4 or more specified anti-epileptics in the absence of an epilepsy Read code in last 12 months.
[3] Four or more laxative prescriptions in the last 12 months

Frailty register – people with moderate or severe frailty	
Proposed new indicator	**IND2**: The practice can produce a register of people with moderate to severe frailty.
Background / Rationale for piloting and consulting on the new indicator	The appropriate use of an evidenced based tool and clinical judgement to identify people aged 65 and over who may be living with moderate or severe frailty was a requirement in the 2017/18 GP contract. Annual medication reviews, recording of falls and explicit consent to activate their enriched SCR are currently limited to people with severe frailty. This register underpins subsequent indicators, it is assumed that the required data are already routinely collected.
Evidence base	NICE guideline NG56 (2016) Multimorbidity: clinical assessment and management. Recommendations 1.4 NICE quality standard QS153 (2017) Multimorbidity. Statement 1.

People with moderate or severe frailty -medication review	
Proposed new indicator	**IND14**: The percentage of patients with moderate or severe frailty and/or multimorbidity who have received a medication review in the last 12 months which is structured, has considered the use of a recognised tool and taken place as a shared discussion.
Background / Rationale for piloting and consulting on the new indicator	Multimorbidity is associated with reduced quality of life, higher mortality, polypharmacy and higher treatment burden, higher rates of adverse drug events and greater health service including unplanned admissions and emergency care. Polypharmacy is often driven by the introduction of multiple medicines intended to prevent further morbidity and mortality but other conditions that reduce life expectancy such as frailty may not be considered. The difference made by each new medicine may be reduced when other medicines are used. A structured medicine review provides an opportunity for medicines optimisation and can lead to a reduction in adverse events by identifying and minimising risks related to prescribing. Clinical outcomes and patient satisfaction are likely to be better when decisions are made jointly between the person taking the medicine and the prescriber.
Evidence base	NICE guideline NG5 (2015) Medicines optimisation: the safe and effective use of medicines to enable to best possible outcomes. Sections 1.4 and 1.6. NICE guideline NG56 (2016) Multimorbidity: clinical assessment and management. Recommendations 1.5.2 and 1.6.11. NICE quality statement QS120 (2016) Medicines optimisation. Statements 1 and 6. NICE quality standard QS153 (2017) Multimorbidity. Statement 4.

Falls prevention	
Proposed new indicator	**IND15.1**: The percentage of patients (aged 65 years and over) with moderate or severe frailty who have been asked whether they have had a fall, about the total number of falls and about the type of falls, in the last 12 months
Background / Rationale for piloting and consulting on the new indicator	Falls in older people are a costly and often preventable health issue. Reducing falls and associated injuries is important for maintaining health and wellbeing amongst older people (PHE 2018a). Falling has an impact on quality of life, health and healthcare costs. People 65 years and over have the highest risk of falling. A history of falls in the past year is a risk factor for falls and is a predictor of further falls. This indicator is intended to identify and minimise any risks relating to falls.
Evidence base	NICE guidance CG161 (2013) Falls in older people: assessing risk and prevention. Recommendations 1.1.1.1, 1.1.2.2. NICE quality standard QS86 (2017) Falls in older people. Statement 1.

Falls prevention	
Proposed new indicator	**IND15.2**: The percentage of patients (aged 65 years and over) with moderate or severe frailty who have been asked whether they have had a fall, about the total number of falls and about the type of falls, in the last 12 months, were found to be at risk and have been provided with advice and guidance with regard to falls prevention (in the last 12 months).
Background / Rationale for piloting and consulting on the new indicator	Falls in older people are a costly and often preventable health issue. Reducing falls and associated injuries is important for maintaining health and wellbeing amongst older people (Public Health England 2018a). Falling has an impact on quality of life, health and healthcare costs. People 65 years and over have the highest risk of falling. A history of falls in the past year is a risk factor for falls and is a predictor of further falls. This indicator is intended to identify and minimise risks relating to falls.
Evidence base	NICE guidance CG161 (2013) Falls in older people: assessing risk and prevention. Recommendations 1.1.1.2, 1.1.3.1, 1.1.9.1 and 1.1.10.2. NICE quality standard QS86 (2017) Falls in older people. Statement 3.

Familial hypercholesterolaemia (FH)

Assessment of patients aged 29 years and under with a high total cholesterol	
Proposed new indicator	**IND8**: The percentage of people aged 29 years and under, with a total cholesterol concentration greater than 7.5 mmol/l that are assessed against the Simon Broome or Dutch Lipid Clinic Network (DLCN) criteria.
Background / Rationale for piloting and consulting on the new indicator	In some people high total cholesterol levels are caused by an inherited gene defect: familial hypercholesterolemia (FH). A raised cholesterol concentration is present from birth and may lead to early development of atherosclerotic disease. There is a greater than 50% increased risk of coronary heart disease (CHD) in men with FH by the age of 50 years. Cardiovascular disease (CVD) remains the second highest cause of premature death and is a major contributor to heath inequalities yet is highly preventable through proven treatments (NHS England 2017). The prevalence of heterozygous FH in the UK population is estimated to be 1 in 250. Currently it is estimated that up to 80% of people with FH are undiagnosed and untreated. Diagnosis is based on the Simon Broome criteria or the Dutch Lipid Clinic Network (DLCN) criteria which includes information on family history, total and LDL cholesterol concentrations, clinical signs such as tendon xanthomata and DNA testing. Considering a diagnosis of FH in primary care will result in greater identification and support cascade testing of relatives. It will lead to more treatment of high cholesterol and the prevention of CHD amongst people with FH. This indicator is intended to increase identification of those with undiagnosed FH.
Evidence base	NICE quality standard QS41 (2013) Familial hypercholesterolaemia. Statement 1. NICE guidance CG71 (2017) Familial hypercholesterolaemia: identification and management. section 1.1

Assessment of patients ages 30 years and older with a high total cholesterol	
Proposed new indicator	**IND9**: The percentage of people aged 30 years and older with a total cholesterol concentration greater than 9.0mmol/l that are assessed against the Simon Broome or Dutch Lipid Clinic Network (DLCN) criteria.
Background / Rationale for piloting and consulting on the new indicator	In some people high total cholesterol levels are caused by an inherited gene defect: familial hypercholesterolemia (FH). A raised cholesterol concentration is present from birth and may lead to early development of atherosclerotic disease. There is a greater than 50% increased risk of coronary heart disease (CHD) in men with FH by the age of 50 years. Cardiovascular disease (CVD) remains the second highest cause of premature death and is a major contributor to heath inequalities yet is highly preventable through proven treatments (NHS England 2017). The prevalence of heterozygous FH in the UK population is estimated to be 1 in 250. Currently it is estimated that up to 80% of people with FH are undiagnosed and untreated. Diagnosis is based on the Simon Broome criteria or the Dutch Lipid Clinic Network (DLCN) criteria which includes information on family history, total and LDL cholesterol concentrations, clinical signs such as tendon xanthomata and DNA testing. Considering a diagnosis of FH in primary care will result in greater identification and support cascade testing of relatives. It will lead to more treatment of high cholesterol and the prevention of CHD amongst people with FH. This indicator is intended to increase identification of those people with undiagnosed FH.
Evidence base	NICE quality standard QS41 (2013) Familial hypercholesterolaemia. Statement 1. NICE guidance CG71 (2017) Familial hypercholesterolaemia: identification and management. section 1.1.

Referral of patients with a clinical diagnosis of FH	
Proposed new indicator	**IND10**: The percentage of people with a clinical diagnosis of FH referred for specialist assessment
Background / Rationale for piloting and consulting on the new indicator	People with familial hypercholesterolaemia (FH) have a raised cholesterol concentration from birth and without treatment have a high chance of developing CVD earlier than most people. There is a greater than 50% increased risk of coronary heart disease (CHD) in men with FH by the age of 50 years. Starting people on the right treatment as early as possible is important but it is estimated that up to 80% of people with FH are undiagnosed and untreated. Diagnosis and management of FH can be complex and is best achieved in specialist services. Referral from primary care for specialist assessment, including DNA testing can confirm a diagnosis. Once an accurate diagnosis has been made, people with FH can receive appropriate treatment and cascade testing can be started to identify affected family members.
Evidence base	NICE quality standard QS41 (2013) Familial hypercholesterolaemia. Statement 2. NICE guidance CG71 (2017) Familial hypercholesterolaemia: identification and management. Recommendations 1.1.6, 1.1.8 and 1.2.2.

Alcohol

Alcohol screening for newly diagnosed hypertension patients.	
Proposed new indicator	**IND46**: The percentage of patients with a new diagnosis of hypertension in the preceding 12 months who have been screened for unsafe drinking using the FAST or AUDIT-C tool in the 3 months before or after the date of entry on the hypertension register.
Background / Rationale for piloting and consulting on the new indicator	Alcohol is a cause of significant public health burden but use is widespread amongst most groups of society. Alcohol is the leading cause of ill-health, early mortality and disability in those aged 15-49 years of age (NHS Digital 2017b). As well as recognised physical health complications of alcohol, it has also been linked to a number of conditions including hypertension and alcohol use can make controlling blood pressure levels more difficult. Tools such as AUDIT-C and FAST can help to identify at risk drinkers who may not be alcohol dependent but drink too much. People with hypertension are at increased risk of developing cardiovascular disease (CVD). CVD remains the second highest cause of premature death and is a major contributor to heath inequalities (NHS England 2017). The risk of CVD can be reduced by treating hypertension and reducing lifestyle risks such as alcohol consumption. This indicator is intended to identify those with at risk alcohol consumption in order to more effectively treat their hypertension.
Evidence base	NICE public health guideline PH24 (2010) Alcohol-use disorders: prevention. Recommendation 9. NICE quality standard QS28 (2015) Hypertension in adults. Statement 5. NICE guideline CG127 (2016) Hypertension in adults: diagnosis and management. Recommendations 1.4.1, 1.4.4, 1.4.9

Alcohol brief intervention for newly diagnosed hypertension patients	
Proposed new indicator	**IND 47**: The percentage of patients with a new diagnosis of hypertension in the preceding 12 months with a FAST score of ≥3 or AUDIT-C score of ≥5 who have received brief intervention to help them reduce their alcohol related risk within 3 months of the score being recorded.
Background / Rationale for piloting and consulting on the new indicator	Alcohol is a cause of significant public health burden but use is widespread amongst most groups of society. Alcohol is the leading cause of ill-health, early mortality and disability in those aged 15-49 years of age (NHS Digital 2017b). Alcohol use can make controlling blood pressure levels more difficult. Tools such as AUDIT-C and FAST can help to identify people that may not be alcohol dependent but would benefit from an reducing their alcohol consumption. The risk of CVD can be reduced by treating hypertension and reducing lifestyle risks such as alcohol consumption. Brief intervention can either comprise of a short session of structured brief advice or an extended brief intervention using motivation techniques. Reviews have shown that interventions in primary care are effective in reducing alcohol consumption (Kaner et al. 2018). This indicator is intended to identify those people who have been given advice to reduce alcohol consumption to help in effective treatment of their hypertension.
Evidence base	NICE public health guideline PH24 (2010) Alcohol-use disorders: prevention. Recommendations 9, 10 and 11. NICE quality standard QS28 (2015) Hypertension in adults. Statement 5. NICE guideline CG127 (2016) Hypertension in adults: diagnosis and management. Recommendations 1.4.1, 1.4.4 and 1.4.9.

Alcohol screening for patients with a new diagnosis of depression or anxiety	
Proposed new indicator	**IND48**: The percentage of patients with a new diagnosis of depression or anxiety in the preceding 12 months who have been screened for unsafe drinking using the FAST or AUDIT-C tool in the 3 months before or after their diagnosis being recorded.
Rationale for the new indicator	Alcohol is a cause of significant public health burden but use is widespread amongst most groups of society. Alcohol is the leading cause of ill-health, early mortality and disability in those aged 15-49 years of age (NHS Digital 2017b). Alcohol misuse contributes to 200 health conditions including depression. It is sometimes used to manage symptoms of anxiety and depression but is likely to make those symptoms worse. In 2017/18 there were 37,285 admission episodes for mental and behavioural disorders due to the use of alcohol (Public Health England, 2019). Tools such as AUDIT-C and FAST can help to identify at risk drinkers who may not be alcohol dependent but drink too much. Managing alcohol intake can reduce risk of developing depression and anxiety and can help to manage symptoms in those with anxiety and depression. This indicator aims to identify people with depression or anxiety who are at risk of unsafe alcohol consumption.
Evidence base	NICE public health guideline PH24 (2010) Alcohol-use disorders: prevention. Recommendation 9. NICE guidance CG123 (2011) Common mental health problems: identification and pathways to care. Recommendation 1.4.1.6.

Alcohol brief intervention for patients with a new diagnosis of depression or anxiety	
Proposed new indicator	**IND49**: The percentage of patients with a new diagnosis of depression or anxiety with a FAST score of ≥3 or AUDIT-C score of ≥5 who have received brief intervention to help them reduce their alcohol related risk within 3 months of the score being recorded.
Rationale for the new indicator	Alcohol is a cause of significant public health burden but use is widespread amongst most groups of society. Alcohol is the leading cause of ill-health, early mortality and disability in those aged 15-49 years of age (NHS Digital 2017b). Alcohol misuse contributes to 200 health conditions including depression. It is sometimes used to manage symptoms of anxiety and depression but is likely to make those symptoms worse. In 2017/18 there were 37,285 admission episodes for mental and behavioural disorders due to the use of alcohol (Public Health England 2019). Tools such as AUDIT-C and FAST can help to identify at risk drinkers who may not be alcohol dependent but drink too much. Brief intervention can either comprise of a short session of structured brief advice or an extended brief intervention using motivation techniques. Reviews have shown that interventions in primary care are effective in reducing alcohol consumption (Kaner et al. 2018). This indicator is intended to identify those people with depression or anxiety who have been given advice to reduce alcohol consumption to better manage their condition.
Evidence base	NICE public health guideline PH24 (2010) Alcohol-use disorders: prevention. Recommendations 9, 10 and 11. NICE guidance CG123 (2011) Common mental health problems: identification and pathways to care. Recommendation 1.4.1.6.

Alcohol brief intervention for patients with schizophrenia, bipolar affective disorder and other psychoses	
Proposed new indicator	**IND50**: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses with a FAST score of ≥3 or AUDIT-C score of ≥5 who have received a brief intervention to help them reduce their alcohol related risk within 3 months of the score being recorded.
Rationale for the new indicator	Substance misuse, including alcohol consumption by people with serious mental health disorders is recognised as a major problem in terms of prevalence and clinical and social effects. Alcohol can cause psychosis and can also interact with anti-psychotic medication (NHS UK [online; accessed 9 April 2019]) Brief intervention can either comprise of a short session of structured brief advice or an extended brief intervention using motivation techniques. Reviews have shown that interventions in primary care are effective in reducing alcohol consumption. This indicator is intended to identify those people with schizophrenia, bipolar affective disorder or other psychoses who have been given advice to reduce alcohol consumption to better manage their condition.
Evidence base	NICE public health guideline PH24 (2010) Alcohol-use disorders: prevention. Recommendations 9, 10 and 11. NICE guideline CG120 (2011) Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings. Recommendations 1.2.1 and 1.3.1. NICE guideline CG178 (2014) Psychosis and schizophrenia in adults: prevention and management. Recommendation 1.3.3.1. NICE guideline CG185 (2014) Bipolar disorder: assessment and management. Recommendation 1.10.2.

Alcohol screening for patients with coronary heart disease (CHD), atrial fibrillation (AF), chronic heart failure, stroke or transient ischaemic attack (TIA), diabetes or dementia	
Proposed new indicator	**IND51**: The percentage of patients with one or more of the following conditions: CHD, atrial fibrillation, chronic heart failure, stroke or TIA, diabetes or dementia who have been screened for unsafe drinking using the FAST or AUDIT-C tool in the preceding 2 years.
Rationale for the new indicator	Alcohol is a cause of significant public health burden, but use is widespread amongst most groups of society. Alcohol is the leading cause of ill-health, early mortality and disability in those aged 15-49 years of age (NHS Digital 2017b). Harmful drinking is associated with multiple physical and mental health problems. In some people these may remit on stopping or reducing alcohol consumption. Tools such as AUDIT-C and FAST can help to identify at risk drinkers who may not be alcohol dependent but drink too much. This indicator intends to identify those people with described morbidities who are at risk of unsafe alcohol consumption. This will help to better manage their conditions. The 2-year timeframe is being presented at consultation as a pragmatic proposal to allow measurement.
Evidence base	NICE public health guideline PH24 (2010) Alcohol-use disorders: prevention. Recommendation 9. NICE guideline CG180 (2014) Atrial fibrillation: management Recommendations 1.4.2 and 1.5.13. NICE guideline CG181 (2016) Cardiovascular disease: risk assessment and reduction, including lipid modification Recommendations 1.1.27, 1.2.13 and 1.3.13.

Alcohol brief intervention for patients with CHD, AF, CHF, stroke or TIA, diabetes or dementia	
Proposed new indicator	**IND52**: The percentage of patients with one or more of the following conditions: CHD, atrial fibrillation, chronic heart failure, stroke or TIA, diabetes or dementia with a FAST score of ≥3 or AUDIT-C score of ≥5 who have received brief intervention to help them reduce their alcohol related risk within 3 months of the score being recorded.
Rationale for the new indicator	Alcohol is a cause of significant public health burden, but use is widespread amongst most groups of society. Alcohol is the leading cause of ill-health, early mortality and disability in those aged 15-49 years of age (NHS Digital 2017b). Harmful drinking is associated with multiple physical and mental health problems. In some people these may remit on stopping or reducing alcohol consumption. Tools such as AUDIT-C and FAST can help to identify at risk drinkers who may not be alcohol dependent but drink too much. Brief intervention can either comprise of a short session of structured brief advice or an extended brief intervention using motivation techniques. Reviews have shown that interventions in primary care are effective in reducing alcohol consumption (Kaner et al. 2018). This indicator is intended to identify those people with described conditions who have been given advice to reduce alcohol consumption to better manage their condition.
Evidence base	NICE public health guideline PH24 (2010) Alcohol-use disorders: prevention. Recommendations 9, 10 and 11. NICE guideline CG180 (2014) Atrial fibrillation: management Recommendations 1.4.2 and 1.5.13. NICE guideline CG181 (2016) Cardiovascular disease: risk assessment and reduction, including lipid modification Recommendations 1.1.27, 1.2.13 and 1.3.13.

New indicators – Local authority

HIV testing in areas with high or extremely high HIV prevalence

HIV testing in newly registered patients	
Proposed new indicator	**IND5**: The percentage of adults and young people newly registered with a GP in an area of high or extremely high HIV prevalence who receive an HIV test within 3 months of registration.
Rationale for the new indicator	In England 79 of 325 local authorities have a high diagnosed prevalence (>2 per 1,000 population) of these 19 have an extremely high prevalence, defined as 5 per 1,000 population (PHE, 2018). Increasing the uptake of HIV testing is important to reduce late diagnosis. Early diagnosis improves treatment outcomes and reduces the risk of transmission. Late diagnosis is the most important predictor of morbidity and premature mortality among people with HIV infection. People diagnosed late are likely to have been living with an undiagnosed HIV infection for around 3 to 5 years and may have been at risk of passing HIV on to partners. One-year mortality among people diagnosed late in 2015 was 26.07 per 1000, compared to 1.62 per 1000 among people diagnosed promptly (Public Health England 2017). Reducing HIV incidence and undiagnosed infection in high-risk populations are key aims of Public Health England (Public Health England 2015). Offering HIV testing routinely in GP surgeries in areas of high and extremely-high prevalence will help to ensure that an HIV test is regarded as routine practice and help reduce stigma.
Evidence base	NICE guidance NG60 (2016): HIV testing: increasing uptake among people who may have undiagnosed HIV. Recommendation 1.1.9. NICE quality standard QS157 (2017): HIV testing: encouraging uptake. Statement 2.

Annual HIV testing in patients having a blood test.	
Proposed new indicator	**IND6**: The percentage of adults and young people at a GP surgery in an area of high or extremely high HIV prevalence who have not had an HIV test in the last 12 months, who are having a blood test and receive an HIV test at the same time.
Rationale for the new indicator	In England 79 of 325 local authorities have a high diagnosed prevalence (>2 per 1,000 population) of these 19 have an extremely high prevalence, defined as 5 per 1,000 population (PHE, 2018). Increasing the uptake of HIV testing is important to reduce late diagnosis. Early diagnosis improves treatment outcomes and reduces the risk of transmitting the infection to others. Late diagnosis is the most important predictor of morbidity and premature mortality among people with HIV infection. People diagnosed late are likely to have been living with an undiagnosed HIV infection for around 3 to 5 years and may have been at risk of passing HIV on to partners. One-year mortality among people diagnosed late in 2015 was 26.07 per 1000, compared to 1.62 per 1000 among people diagnosed promptly (Public Health England 2017). Reducing HIV incidence and undiagnosed infection in high-risk populations are key aims of Public Health England (Public Health England 2015). Offering HIV testing routinely in GP surgeries in areas of high and extremely-high prevalence will help to ensure that an HIV test is regarded as routine practice and reduce stigma.
Evidence base	NICE guidance NG60 (2016): HIV testing: increasing uptake among people who may have undiagnosed HIV. Recommendation 1.1.9. NICE quality standard QS157 (2017): HIV testing: encouraging uptake. Statement 2.

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Appendix A: Consultation comments

Consultation dates: 17/04/2019 to 16/05/2019

General comments:

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

1. Do you think there are any barriers to implementing the care described by these indicators?
2. Do you think there are potential unintended consequences to implementing/ using any of these indicators?
3. Do you think there is potential for differential impact (in respect of age, disability, gender and gender reassignment, pregnancy and maternity, race, religion or belief, and sexual orientation)? If so, please state whether this is adverse or positive and for which group.
4. 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?

How to submit your comments:

Please send your comments using the form available on the NICE website to indicators@nice.org.uk by 5pm on Thursday 16/05/2019.