**Comments Proforma – Consultation on NICE indicators**

We would like to hear your views on the proposed amendments and additions to the NICE indicators for:

- asthma, COPD, heart failure – these indicators have been amended as a result of reviewing existing QOF indicators;
- multi-morbidity, frailty, familial hypercholesterolaemia and alcohol - these indicators are currently being piloted in general practice and may be suitable for a national measurement framework;
- HIV testing – these indicators are intended for use in general practice in specified areas of high or extremely high prevalence only

Do you have any general comments on these indicators?

When commenting on these indicators you may also wish to consider whether:

- the proposed indicators will lead to improvements in care and outcomes for patients?
- there are any barriers to implementing the care described?
- there are potential unintended consequences to implementing / using the indicators?
- 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.

The [consultation document](#) should be read before making comments on the topic areas listed in this document. Please be clear which indicator you are commenting on where your comment is specific to an individual indicator.

Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly.

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<table>
<thead>
<tr>
<th>Organisation name – Stakeholder or respondent (if you are responding as an individual rather than a registered stakeholder please leave blank):</th>
<th>British Medical Association</th>
</tr>
</thead>
</table>
| Disclosure
Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry. | None |
| Name of commentator person completing form: | Catharina Ohman, Senior Policy Advisor, General Practitioners Committee Secretariat |
| Type | [office use only] |

<table>
<thead>
<tr>
<th>Comment number</th>
<th>Indicator ID</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>IND63 (Asthma)</td>
<td>IND63: The contractor establishes and maintains a register of patients with asthma aged 5 or over. We support the changes to this indicator.</td>
</tr>
<tr>
<td>2</td>
<td>IND64 (Asthma)</td>
<td>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. We support the changes to this indicator.</td>
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</tbody>
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<tbody>
<tr>
<td>3</td>
<td>IND65 (Asthma)</td>
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</table>
|   | 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.  
We support the changes to this indicator.  |
| 4 | IND66 (Asthma)  |
|   | 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.  
We support the changes to this indicator.  |
| 5 | IND67 (COPD)  |
|   | 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.  
We support the changes to this indicator.  |
| 6 | IND68 (COPD)  |
|   | 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.  
We support the changes to this indicator.  |
| 7 | IND69 (HF)  |
|   | 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  
We support the changes to this indicator.  |
| 8 | IND70 (HF)  |
|   | IND70: The percentage of patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, who are currently treated with an ACE-I or ARB  
We support the changes to this indicator. Note that the word ‘failure’ is missing in the indicator wording.  |
| 9 | IND71 (HF)  |
|   | 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.  
We support the changes to this indicator.  |
| 10 | IND72 (HF)  |
|   | 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.  
We support the changes to this indicator.  |

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<th>Text</th>
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<tbody>
<tr>
<td>11</td>
<td>IND1 (Multimorbidity)</td>
<td>New IND1: The practice can produce a register of people with multimorbidity who would benefit from a tailored approach to care. We support the aim of identifying patients with multimorbidity but in order for this to be useful a quality measure there would need to be agreement concerning the IT tools available to populate the register in a reliable manner, and to differentiate between multimorbidity and frailty.</td>
</tr>
<tr>
<td>12</td>
<td>IND2 (Frailty)</td>
<td>New IND2: The practice can produce a register of people with moderate to severe frailty We support the inclusion of this new indicator.</td>
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<tr>
<td>13</td>
<td>IND14 (Frailty)</td>
<td>New 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. We recognise the importance of medication reviews in these patients but consider the wording of this proposed indicator to be over-prescriptive and not emphasise sufficiently the importance of deprescribing. We would recommend alteration of the wording to ‘The percentage of patients with moderate or severe frailty and/or multimorbidity who have (or their carers have) participated in a medication review in the last 12 months which included consideration of deprescribing.’</td>
</tr>
<tr>
<td>14</td>
<td>IND15.1 (Frailty)</td>
<td>New 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 Should be this aligned with the wording in the GMS contract, then we could support: ‘The percentage of patients (aged 65 years and over) with moderate or severe frailty who have had a discussion about whether they have fallen, recorded in the last 12 months’ We believe that patient or carer recall of numbers of falls is likely to be poor and recording inaccurate.</td>
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<tr>
<td>15</td>
<td>IND15.2 (Frailty)</td>
<td>New 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). We oppose this indicator. Our concerns regarding IND15.1 apply here too and the professionalism of the clinician should be relied on to take appropriate action once a significant problem has been identified. This indicator is likely to become an automatic ‘tick-box’ exercise and so the recording will not indicate whether useful help has been offered.</td>
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<tr>
<td>16</td>
<td>IND8 (Cholesterol)</td>
<td>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</td>
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</tbody>
</table>
### New Indicators

**IND9** *(Cholesterol)*

> **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.

While agreeing that this represents best practice, we cannot support this as an indicator of quality as the numbers in each practice will be too low to provide an acceptable indication of standards of care.

**IND10** *(FH)*

> **IND10:** The percentage of people with a clinical diagnosis of FH referred for specialist assessment.

While agreeing that this represents best practice, we cannot support this as an indicator of quality as the numbers in each practice will be too low to provide an acceptable indication of standards of care.

**IND46** *(Hypertension)*

> **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.

We cannot support this as an indicator of quality as the numbers in each practice will be too low to provide an acceptable indication of standards of care.

**IND47** *(Hypertension)*

> **IND47:** The percentage of patients with a new diagnosis of hypertension in the preceding 12 months with a FAST score of $\geq 3$ or AUDIT-C score of $\geq 5$ who have received brief intervention to help them reduce their alcohol related risk within 3 months of the score being recorded.

We oppose this indicator. Our concerns regarding IND46 apply here too and the professionalism of the clinician should be relied on to take appropriate action once a significant problem has been identified. This indicator is likely to become an automatic ‘tick-box’ exercise and so the recording will not indicate whether useful help has been offered.

**IND48** *(Dep/Anxiety)*

> **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.

While agreeing that this represents best practice, we cannot support this as an indicator of quality as the numbers in each practice will be too low to provide an acceptable indication of standards of care.

**IND49** *(Dep/Anxiety)*

> **IND49:** The percentage of patients with a new diagnosis of depression or anxiety with a FAST score of $\geq 3$ or AUDIT-C score of $\geq 5$ who have received brief intervention to help them reduce their alcohol related risk within 3 months of the score being recorded.

We oppose this indicator. Our concerns regarding IND48 apply here too and the professionalism of the clinician should be relied on to take appropriate action once a significant problem has been identified. This indicator is likely to become an automatic ‘tick-box’ exercise and so the recording will not indicate whether useful help has been offered.
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23 IND50 (Schiz/Bipolar)
New
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.

We cannot support this as an indicator of quality as the numbers in each practice will be too low to provide an acceptable indication of standards of care. The professionalism of the clinician should be relied on to take appropriate action once a significant problem has been identified. This indicator is likely to become an automatic ‘tick-box’ exercise and so the recording will not indicate whether useful help has been offered.

24 IND52 (Alcohol)
New
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.

We do not support this indicator, as the professionalism of the clinician should be relied on to take appropriate action once a significant problem has been identified. This indicator is likely to become an automatic ‘tick-box’ exercise and so the recording will not indicate whether useful help has been offered.

25 IND5 (HIV)
New
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.

We oppose this indicator. This is a form of population screening and so should only take place if assessed as worthwhile by the UK National Screening Committee and with appropriate contracts in place to provide the service. Screening activities are excluded from the General Medical Services Contract and as such are not suitable for quality standards, unless a contracted service has been agreed.

26 IND6 (HIV)
New
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.

We oppose this indicator. This is a form of population screening and so should only take place if assessed as worthwhile by the UK National Screening Committee and with appropriate contracts in place to provide the service. Screening activities are excluded from the General Medical Services Contract and as such are not suitable for quality standards, unless a contracted service has been agreed.

Patients should always receive adequate counselling before HIV testing and be allowed to have time to consider the implications of the test. This is unlikely to be able to be provided in the busy atmosphere of a phlebotomy clinic, as scheduling adequate time for counselling before every appointment would not be possible.

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Checklist for submitting comments

• Use this comment form and submit it as a Word document (not a PDF).
• Complete the disclosure about links with, or funding from, the tobacco industry.
• Include the indicator ID for the indicator you are commenting on.
• Combine all comments from your organisation into 1 response. We cannot accept more than 1 response from each organisation.
• Do not paste other tables into this table – type directly into the table.
• Mark any confidential information or other material that you do not wish to be made public. Also, ensure you state in your email to NICE that your submission includes confidential comments.
• Do not include medical information about yourself or another person from which you or the person could be identified.
• Spell out any abbreviations you use.
• For copyright reasons, comment forms do not include attachments such as research articles, letters or leaflets (for copyright reasons). We return comments forms that have attachments without reading them. The stakeholder may resubmit the form without attachments, but it must be received by the deadline.
• We do not accept comments submitted after the deadline stated for close of consultation.

You can see any guidance that we have produced on topics related to these indicators by checking NICE Pathways.

Note: We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate.

Comments received during our consultations are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the comments we received, and are not endorsed by NICE, its officers or advisory Committees. Further information regarding our privacy information can be found at our privacy notice on our website.

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