Consultation on new NICE indicators: March 2024

**Introduction**

NICE indicators are developed in accordance with the [NICE indicator process guide](https://www.nice.org.uk/standards-and-indicators). A key part of this process is giving stakeholders the opportunity to comment on the proposed indicators and their intended use. This consultation includes two types of indicators: those potentially suitable for use in the Quality and Outcomes Framework ([section 1](#_Section_1:_New)) and those suitable for use at network or system level ([section 2](#_Section_2:_New)). As part of development, and at the same time as consultation, we will be using a research database of primary care data to quantify population sizes and gain insight into current achievement levels.

**The proposed indicators may change following consultation.**

We welcome comments from stakeholders and consultation closes Thursday 28 March 2024. If you have any questions, please contact [indicators@nice.org.uk](mailto:indicators@nice.org.uk). Feedback will be reviewed by the NICE Indicator Advisory Committee in June 2024. Stakeholders are asked to consider the following questions:

1. Do you think the proposed indicators will lead to improvements in care and outcomes for patients?
2. Are there any barriers to implementing the care described?
3. Are there are potential unintended consequences to implementing and using the indicators?
4. Is there 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.

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# Section 1: New indicators suitable for use in QOF

This consultation presents new indicators potentially suitable for inclusion in the Quality and Outcomes Framework (QOF) focused on:

* Cardiovascular disease prevention: risk assessment
* COPD
* Postnatal support

These proposed indicators should not be considered as final QOF indicators. QOF forms part of the GMS contract, and the content of QOF is determined by negotiations between NHS England and the BMA’s General Practitioners Committee.

The Department for Health and Social Care is currently holding a consultation on the role of incentivisation in general practice which may affect how and if these indicators progress to publication.

## IND2023-164 Cardiovascular disease prevention: Risk assessment (general population)

The percentage of people aged 45 to 84 years who have a recorded CVD risk assessment score in the preceding 5 years.

### Indicator type

General practice indicator suitable for use in the QOF.

### Rationale

For primary prevention of cardiovascular disease (CVD), NICE guidance recommends using a systematic strategy in primary care to identify people who are likely at high risk of CVD. Once an increased risk has been found, many CVD risk factors are modifiable through lifestyle changes or medical interventions.

QRISK3 is validated in people aged 40 to 84 years. This indicator uses a population aged 45 to 84 years to provide a 5-year window in which the initial risk assessment can take place. A frequency of 5 years for repeat CVD risk assessment was chosen to align with the NHS Health Check programme. CVD risk can be estimated based on existing factors already recorded in primary care electronic medical records.

### Source guidance

NICE’s guideline on [cardiovascular disease: risk assessment and reduction, including lipid modification](https://www.nice.org.uk/guidance/ng238). NICE guideline NG238 (2023), recommendations 1.1.1 and 1.1.2.

### Specification

Numerator: The number of people in the denominator with a recorded CVD risk assessment score in the preceding 5 years

Denominator: The number of people aged 45 to 84 years.

Exclusions: People with any of the following:

* Type 1 diabetes
* CVD
* Familial hypercholesterolemia
* CKD 3a to 5
* Current treatment with lipid lowering therapies
* 20% risk ever recorded.

Definitions:

CVD risk assessment should preferably be undertaken using QRISK3; however, proposed indicator construction would include clinical codes for QRISK, QRISK2, QRISK3, Framingham and Joint British Societies risk scores. For this indicator, estimated risk scores would be acceptable using factors already recorded in primary care electronic medical records.

Current lipid lowering therapies is defined as a prescription of statins or other lipid lowering therapies in the last 6 months of reporting period.

Cardiovascular disease is defined as angina, previous myocardial infarction, revascularisation, ischaemic stroke or TIA or symptomatic peripheral arterial disease. Existing NHS QOF registers could be used: CHD001, STIA001 excluding people with a history of haemorrhagic stroke, and PAD001.

### Questions for consultation

1. Given the existing NHS Health Check Programme, is there added value in this indicator focused on CVD risk assessment?
2. NICE is currently testing the indicator using a primary care research database given the likely large number of eligible patients per practice. Would you expect the potential large numbers of eligible patients per practice to be a substantial barrier to implementation? What achievement level could represent an acceptable target for improvement?
3. Would indicators IND2023-165 and IND2023-166 be more pragmatic approaches to increasing CVD risk assessment in at risk populations?

## IND2023-165 Cardiovascular disease prevention: Risk assessment (modifiable risk factors or comorbidities)

The percentage of people aged 43 to 84 years with a modifiable risk factor or comorbidity who have a recorded CVD risk assessment score in the preceding 3 years.

### Indicator type

General practice indicator suitable for use in the QOF.

### Rationale

For primary prevention of cardiovascular disease (CVD), NICE guidance recommends using a systematic strategy in primary care to identify people who are likely at high risk of CVD. Once an increased risk has been found, many CVD risk factors are modifiable through lifestyle changes or medical interventions.

This indicator focuses on those who have modifiable risk factors or comorbidities as highlighted in the QRISK3 assessment tool because these patients are more likely to have higher CVD risk.

QRISK3 is validated in people aged 40 to 84 years. This indicator uses a population aged 43 to 84 years to provide a 3-year window in which the initial risk assessment can take place. A frequency of 3 years was chosen because cardiovascular risk may change more rapidly in people with a modifiable risk factor or comorbidity. CVD risk can be estimated based on existing factors already recorded in primary care electronic medical records.

### Source guidance

NICE’s guideline on [cardiovascular disease: risk assessment and reduction, including lipid modification](https://www.nice.org.uk/guidance/ng238). NICE guideline NG238 (2023), recommendations 1.1.1 and 1.1.2.

### Specification

Numerator: The number of people in the denominator with a recorded CVD risk assessment score in the preceding 3 years.

Denominator: The number of people aged 43 to 84 years with one or more of the following:

* Current smoker
* Obesity (last recorded BMI of 30kg/m2 or more)
* Hypertension
* Hypercholesterolemia
* Type 2 diabetes
* Erectile dysfunction
* Serious mental illness
* Rheumatoid arthritis
* Systemic lupus erythematosus
* Atrial fibrillation

Exclusions: People with any of the following:

* Type 1 diabetes
* Cardiovascular disease
* Familial hypercholesterolemia
* CKD 3a to 5
* Current lipid lowering therapies
* 20% risk ever recorded.

Definitions:

CVD risk assessment should preferably be undertaken using QRISK3; however, proposed indicator construction would include clinical codes for QRISK, QRISK2, QRISK3, Framingham and Joint British Societies risk scores. For this indicator, estimated risk scores would be acceptable using factors already recorded in primary care electronic medical records.

Current lipid lowering therapies is defined as a prescription of statins or other lipid lowering therapies in last 6 months of reporting period.

Cardiovascular disease is defined as angina, previous myocardial infarction, revascularisation, ischaemic stroke or TIA or symptomatic peripheral arterial disease. Existing QOF registers could be used: CHD001, STIA001 excluding people with a history of haemorrhagic stroke, and PAD001.

Serious mental illness is defined as schizophrenia, bipolar affective disorder and other psychoses. Existing QOF register MH1\_REG could be used.

### Questions for consultation

1. Given the existing NHS Health Check Programme, is there added value in this indicator focused on CVD risk assessment specifically in people with a modifiable risk factor or comorbidity?
2. NICE is currently testing the indicator using a primary care research database given the likely large number of eligible patients per practice. Would you expect the potential large numbers of eligible patients per practice to be a substantial barrier to implementation? What achievement level could represent an acceptable target for improvement?

## IND2023-166 Cardiovascular disease prevention: Risk assessment (modifiable risk factors)

The percentage of people aged 43 to 84 years with a modifiable risk factor who have a recorded CVD risk assessment score in the preceding 3 years.

### Indicator type

General practice indicator suitable for use in the QOF.

### Rationale

For primary prevention of cardiovascular disease (CVD), NICE guidance recommends using a systematic strategy in primary care to identify people who are likely at high risk of CVD. Once an increased risk has been found, many CVD risk factors are modifiable through lifestyle changes or medical interventions.

This indicator focuses on those who have modifiable risk factors as highlighted in the QRISK3 assessment tool because these patients are more likely to have higher CVD risk. This indicator may provide a more pragmatic approach to identifying people likely to be at high risk, with fewer patients per practice than the two previous indicators in this consultation.

QRISK3 is validated in people aged 40 to 84 years. This indicator uses a population aged 43 to 84 years to provide a 3-year window in which the initial risk assessment can take place. A frequency of 3 years was chosen because cardiovascular risk may change more rapidly in people with a modifiable risk factor. CVD risk can be estimated based on existing factors already recorded in primary care electronic medical records.

### Source guidance

NICE’s guideline on [cardiovascular disease: risk assessment and reduction, including lipid modification](https://www.nice.org.uk/guidance/ng238). NICE guideline NG238 (2023), recommendations 1.1.1 and 1.1.2.

### Specification

Numerator: The number of people in the denominator with a recorded CVD risk assessment score in the preceding 3 years.

Denominator: The number of people aged 43 to 84 years with one or more of the following:

* Current smoker
* Obesity
* Hypertension
* Hypercholesterolemia

Exclusions: People with any of the following:

* Type 1 diabetes
* Cardiovascular disease
* Familial hypercholesterolemia
* CKD 3a to 5
* Current lipid lowering therapies
* 20% risk ever recorded.

Definitions:

CVD risk assessment should preferably be undertaken using QRISK3; however, proposed indicator construction would include clinical codes for QRISK, QRISK2, QRISK3, Framingham and Joint British Societies risk scores. For this indicator, estimated risk scores would be acceptable using factors already recorded in primary care electronic medical records.

Current lipid lowering therapies is defined as a prescription in last 6 months of reporting period.

Cardiovascular disease is defined as angina, previous myocardial infarction, revascularisation, ischaemic stroke or TIA or symptomatic peripheral arterial disease. Existing NHS QOF registers could be used: CHD001, STIA001 excluding people with a history of haemorrhagic stroke, and PAD001.

### Questions for consultation

1. Given the existing NHS Health Check Programme, is there added value in this indicator focused on CVD risk assessment specifically in people with a modifiable risk factor?
2. Is only including people with a modifiable risk factor an acceptable pragmatic option for focusing on people at increased risk?
3. NICE is currently testing the indicator using a primary care research database given the likely large number of eligible patients per practice. Would you expect the potential large numbers of eligible patients per practice to be a substantial barrier to implementation? What achievement level could represent an acceptable target for improvement?

## IND2023-167 COPD: annual review (high risk)

The percentage of people with COPD at higher risk of hospital admission 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.

### Indicator type

General practice indicator suitable for use in the QOF

### Rationale

NICE guidance recommends that all people with COPD are reviewed at least annually, and this is reflected in the existing NICE indicator [NM170](https://www.nice.org.uk/standards-and-indicators/qofindicators/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) (QOF COPD010). Assessment of a patient’s condition can help support self-management, identify triggers and avoid future exacerbations. This indicator is complementary to NM170 and focuses on those most at risk of hospital admission to support effective targeting of available resources.

### Source guidance

NICE’s guideline on [chronic obstructive pulmonary disease in over 16s](https://www.nice.org.uk/guidance/ng115) (2018, updated 2019) recommendation 1.1.25 and 1.2.138.

### Specification

Numerator: The number of people in the denominator 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.

Denominator: The number of people with COPD at higher risk of hospital admission.

Definition: Higher risk of hospital admission is defined as the presence of any of the following in people with COPD (based on the NICE guideline and data availability):

* Last recorded FEV1 <30%.
* Last recorded smoking status: current smoker.
* MRC greater than or equal to 3 in the previous 12 to 24 months.
* Exacerbations greater than or equal to 2 in the previous 12 to 24 months.
* Hospital admission for an exacerbation of COPD in the previous 12 to 24 months.
* Patients on existing QOF registers for cancer, coronary heart disease, atrial fibrillation, heart failure, learning disability or serious mental illness.
* Last recorded frailty status: moderate or severe.

Exclusions: None.

Personalised care adjustments or exception reporting should be considered to account for situations where the patient declines or does not attend.

### Questions for consultation

1. Is the proposed definition of ‘higher risk of hospital admission’ a practical and valid approach? If not, please say why?
2. NICE is currently testing the indicator using a primary care research database. Would you expect the proposed definition of patients at ‘higher risk of hospital admission’ to be a substantial proportion of all patients with COPD? Are there any risk factors that should be focused on?

## IND2023-156 Postnatal support: 6-week postnatal check

The percentage of women who gave birth in the preceding 12 months who had a GP postnatal check 6 to 12 weeks after giving birth.

### Indicator type

General practice indicator suitable for use in the QOF.

### Rationale

Postnatal checks are an essential component of ensuring good maternal health, as they cover physical and mental health, contraception and a review of any chronic conditions.

Ensuring that women's physical and psychological health and wellbeing is comprehensively assessed after giving birth, and managing any identified problems appropriately, can prevent delays in diagnosing and treating any issues, and improve care.

NICE guidance states this check should be carried out 6 to 8 weeks following birth. The indicator uses an extended time window of 12 weeks as a practical acknowledgement of the realities in clinical practice and feedback that the maternal check often takes place at the same time as the baby has their first immunisation appointment.

### Source guidance

NICE’s guideline on [postnatal care](https://www.nice.org.uk/guidance/ng194), NICE guideline NG194 (2021), recommendation 1.2.7.

### Specification

Numerator: The number of women in the denominator who had a GP postnatal check 6 to 12 weeks after giving birth.

Denominator: The number of women who gave birth in the preceding 12 months.

Definition: None.

Exclusions: None.

Personalised care adjustments or exception reporting should be considered to account for situations where the patient gave birth in the last three months of the reporting period, declines or does not attend.

### Question for consultation

1. Is an extended time window of 12 weeks an acceptable approach to accommodate the realities of clinical practice and feedback that the maternal check often takes place at the same time as the baby has their first immunisation appointment?

# Section 2: New indicators suitable for use at network or system level

This consultation also presents new indicators suitable for use at network or system level. They are not presented as suitable for use in QOF because of likely low numbers of patients at practice level. The new indicators are focused on:

* Postnatal support
* Smoking

## IND2023-160 Postnatal support: 6-week postnatal check (complex social factors)

The percentage of women with complex social factors who gave birth in the preceding 12 months who had a GP postnatal check 6 to 12 weeks after giving birth.

### Indicator type

Network / system level indicator

### Rationale

Postnatal checks are an essential component of ensuring good maternal health, as they cover physical and mental health, contraception and a review of any chronic conditions. Women with complex social factors may have additional needs which can also be discussed as part of the postnatal check, meaning additional support can be offered.

Ensuring that women's physical and psychological health and wellbeing is comprehensively assessed after giving birth, and managing any identified problems appropriately, can prevent delays in diagnosing and treating any issues, and improve care.

NICE guidance states this check should be carried out 6 to 8 weeks following birth. The indicator uses an extended time window of 12 weeks as a practical acknowledgement of the realities in clinical practice and feedback that the maternal check often takes place at the same time as the baby has their first immunisation appointment.

### Source guidance

NICE’s guideline on [postnatal care](https://www.nice.org.uk/guidance/ng194). NICE guideline NG194 (2021), recommendation 1.2.7.

### Specification

Numerator: The number of women in the denominator who had a GP postnatal check 6 to 12 weeks after giving birth.

Denominator: The number of women with complex social factors who gave birth in the preceding 12 months.

Definition:

Based on NICE’s guideline on [pregnancy and complex social factors](https://www.nice.org.uk/Guidance/CG110), complex social factors includes:

* women who misuse substances
* recent migrants, asylum seekers or refugees, or women who have difficulty reading or speaking English
* young women aged under 20
* women who experience domestic abuse.

Presence of complex social factors is recorded as part of the Maternity Services data set. As part of indicator development, we will test the feasibility of linking primary care data with the Maternity Services Dataset.

Exclusions: None.

### Question for consultation

1. Is an extended time window of 12 weeks an acceptable approach to accommodate the realities of clinical practice and feedback that the maternal check often takes place at the same time as the baby has their first immunisation appointment?

## IND2023-161 Smoking: cessation success in people with bipolar, schizophrenia and other psychoses

The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses recorded as current smokers in the previous 1 to 3 years, who were recorded as ex-smokers in the preceding 12 months.

### Indicator type

Network / system level indicator

### Rationale

People with a long term mental health condition are more likely to smoke than the rest of the population and smoking prevalence increases with severity of condition. [Local Tobacco Control Profiles](https://fingertips.phe.org.uk/profile/tobacco-control) from the Office for Health Improvement and Disparities show that 13% of the adults in the general population or current smokers, but prevalence is 25% in adults with long term mental health condition (2021/22 data). Older data from 2014/15 show that around 40% of people with serious mental illness are current smokers.

### Source guidance

NICE’s guideline on [psychosis and schizophrenia in adults](https://www.nice.org.uk/guidance/cg178). CG178 (2014), recommendation 1.1.3.3.

### Specification

Numerator: The number of patients in the denominator recorded as ex‑smokers in the preceding 12 months.

Denominator: The number of patients with schizophrenia, bipolar affective disorder and other psychoses recorded as current smokers in the previous 1 to 3 years.

Definition: None.

Exclusions: None.