

# NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

## QUALITY AND OUTCOMES FRAMEWORK (QOF) INDICATOR DEVELOPMENT PROGRAMME

### Cost impact statement: diabetes

**Proposed change to QOF indicator:** DM13

**Date:** July 2012

#### **Indicator**

NM59: The percentage of patients with diabetes who have a record of an albumin:creatinine ratio (ACR) testing in the preceding 15 months.

#### **Introduction**

This report covers a proposed change to 1 existing Quality and Outcomes Framework (QOF) indicator relating to diabetes. Following a recommendation of the independent QOF advisory committee in June 2012, it is proposed that the existing DM13 indicator is reworded to remove 'exception reporting for proteinuria' from indicator wording and amend to albumin:creatinine ratio (ACR) testing, as NICE clinical guideline 87 on [type 2 diabetes](#) recommends ACR testing irrespective of nephropathy. The wording of the current DM13 indicator is:

DM13: The percentage of patients with diabetes who have a record of microalbuminuria testing in the preceding 15 months (exception reporting for patients with proteinuria).

The rationale for the proposed change is to ensure that the indicator and its supporting technical specifications (business rules) are consistent with NICE guidance on ACR testing in people with diabetes. At present, people with proteinuria are excluded from the indicator denominator, and are not omitted

from the indicator denominator through 'exception reporting' as suggested by the indicator wording. The change will mean that people with proteinuria will now be included in the indicator.

Additionally, the proposed rewording improves the clarity of the intent of the wording to ensure that the test should be done.

This report considers the likely cost impact of the proposed change to this indicator in terms of the number of additional interventions provided and the cost of each intervention. Costs to NHS commissioners are outlined where relevant, along with the cost of additional activity at general practices.

## **Cost implication**

### ***Number of people affected***

In 2010/11, the number of people on GPs' QOF diabetes registers (aged 17 and over) in England was 2,455,937 (an estimated prevalence of 5.5% for people aged 17 and over on GP lists).<sup>1</sup>

The eligible population for DM13 in 2010/11 was 2,334,708 (the indicator denominator plus those who were eligible for the denominator but exception reported).

The proposed change means that people with proteinuria will not be excluded from the new NM59 indicator. The potential denominator for the new indicator may be assumed from the 2010/11 figure for the DM02 indicator (people with diabetes whose notes record BMI), which is not subject to the exclusion of people with proteinuria. The potential denominator for DM02 was 2,455,676 in 2010/11.

This suggests that the revised indicator (NM59) could have an additional 121,000 people in its denominator.

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<sup>1</sup> All 2010/11 QOF data are from [Health and Social Care Information Centre](#), October 2011.  
QOF cost impact statement: proposed change to DM13 indicator (August 2012)

## ***Current care***

In 2010/11, achievement for indicator DM13 across all practices in England was 89.0%, based on a numerator of 1,967,636 and a denominator of 2,210,804.

In 2010/11 the exception reporting rate for DM13 was 5.3%, based on 123,904 exception-reported people.

Current achievement relates to microalbuminuria testing. While the intent of DM13 was to carry out ACR testing (as outlined in the revised indicator wording), other tests may have been carried out when practitioners interpreted the intent of the indicator. For the purpose of this report we have assumed that the intent of DM13 was correctly interpreted. We have not assessed the change in the cost of carrying out an ACR in people currently included in the denominator for DM13 from a different test, for example a urine stix test or a polymerase chain reaction (PCR) test.

The code clusters supporting the revised indicator have been updated. Table 1 shows the current code clusters for DM13, and table 2 shows the revised code clusters for NM59.

**Table 1: Code clusters used for micro-albuminuria testing for DM13**

44ID.	Urine protein/creatinine ratio
467A.	24 hour urine protein output
467E.	Urine protein level
467H.	Random urine protein level
46N3.	Urine total protein
46N4.	Urine albumin
46N5.	24 hour urine protein excretion test
46N6.	24 hour urine albumin output
46N7.	Urine protein/creatinine index
46N8.	Urine microalbumin profile
46TC.	Urine albumin:creatinine ratio
46W..	Urine microalbumin
46W0.	Urine microalbumin positive
46W1.	Urine microalbumin negative
46W2.	Microalbumin excretion rate

**Table 2: Code clusters to be used for ACR testing for NM59**

46TC.	Urine albumin:creatinine ratio
46TD.	Urine microalbumin:creatinine ratio

### ***Proposed care***

An ACR test looks for the presence of microalbuminuria and diabetic nephropathy. Promptly detecting and treating these complications of diabetes can lead to improved health outcomes such as reduction in renal failure and cardiovascular morbidity and mortality.

### ***Resource impact***

It is assumed that the potential denominator will increase by 5% (based on the difference between the 2010/11 potential denominators for DM02 and DM13), and that the level of exception reporting will remain unchanged at 5.3%. A further assumption is that the level of achievement for ACR testing will be 89%, comparable with microalbuminuria testing.

Achievement for NM59 would therefore be based on a denominator of 2,325,352, with the numerator of 2,069,717 (people for whom the indicator

was achieved) being an increase of 102,081 on the DM13 numerator for 2010/11.

The maximum payment threshold for DM13 is currently 90%. If NM59 is assumed to have the same maximum payment threshold and 89% achievement, there would only be a financial incentive to increase achievement for the indicator by 1%. If achievement increased to 90% with a 5.3% exception rate, the numerator would be 2,092,973, an increase of 125,337 on the DM13 numerator for 2010/11 (table 3).

If zero exceptions were assumed, 89% achievement for NM59 would be based on a denominator of 2,455,676, with the numerator of 2,185,552 being an increase of 217,916 on the DM13 numerator for 2010/11. If achievement increased to 90%, the numerator would be 2,210,108, an increase of 242,472 on the DM13 numerator for 2010/11 (table 3).

### ***Cost impact***

The unit cost of an ACR test is £2.16<sup>2</sup>. Table 3 shows that the cost of potential additional tests ranges from £523,789 to £270,773 when the exception rate is assumed to vary from 0% to 5.3%.

Although some of the additional people may already receive ACR tests that are not currently captured by QOF data, we have assumed that if people have proteinuria then they have not had an ACR test.

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<sup>2</sup> NICE commissioning and benchmarking tool: [early identification and management of chronic kidney disease in adults](#).

**Table 3: Summary of cost impact**

	<b>DM13 2010/11</b>	<b>NM59 assuming 5.3% exception rate</b>	<b>NM59 assuming 0% exception rate</b>
Eligible population	2,334,708	2,455,676	2,455,676
Exception percentage	5.3%	5.3%	0%
Exception number	123,904	130,151	-
Denominator	2,210,804	2,325,525	2,455,676
% achievement	89%	90%	90%
Number achieved	1,967,636	2,092,973	2,210,108
Increase in number achieved	-	125,337	242,472
Cost per test	-	£2.16	£2.16
Cost of additional tests	-	£270,727	£523,740

### ***Conclusion***

The cost of potential additional tests arising from including people with proteinuria in the indicator denominator ranges from £270,773 to £523,789 when the exception rate is assumed to vary from 5.3% to 0%, and at an achievement level of 90%.