NICE National Institute for Health and Care Excellence

Focus group report: CKD SGLT2i indicators

Contents

Background

In April 2023, NICE held online focus groups with 9 members of the NICE GP reference Panel to provide feedback on draft indicators. Composition of the focus groups is included in Appendix 1. This report focuses on three options related to chronic kidney disease (CKD):

2022-142: The percentage of patients on the CKD register and currently treated with an ARB or ACE inhibitor who are also currently treated with an SGLT2 inhibitor if they have either:

- a urine ACR of 22.6 mg/mmol or more
- type 2 diabetes and a urine ACR over 30 mg/mmol.

2022-135: The percentage of patients on the CKD register and currently treated with an ARB or an ACE inhibitor who are also currently treated with an SGLT2 inhibitor if they have either:

- a urine ACR of 22.6 mg/mmol or more
- type 2 diabetes and a urine ACR 3 mg/mmol or more.

2022-143: The percentage of patients on the CKD register and currently treated with an ARB or an ACE inhibitor who are also currently treated with an SGLT2 inhibitor if they have either:

- a urine ACR of 22.6 mg/mmol or more
- type 2 diabetes.

Focus group purpose

To provide feedback on whether the indicators:

- have the potential to improve outcomes and address under- or over-treatment?
- would have unreasonable workload implications or burden of data collection?
- focus on actions within control of general practice?
- have any potential unintended consequences?

Feedback

Potential to improve outcomes

There were mixed views on which of the three indicators had the most potential to improve patient outcomes. Some attendees favoured IND2022-142 because of its closer alignment to the strongest recommendation in the NICE diabetes guideline. Some attendees favoured whichever was simplest to implement in practice as all were supported by the NICE guidance to some extent.

Some attendees felt that provision of SGLT2i for CKD was inappropriate for use in an incentivised framework such as the QOF, as it could risk over treatment. SGLT2i were felt to be options for treatment in some cases, but not appropriate for all patients. National quality improvement could instead focus on other aspects such as the retired CKD QOF indicators (blood pressure, cholesterol levels and ACR testing).

For all three options, concerns were raised around the inclusion of some older people for whom intensifying treatment may be inappropriate and lead to limited improvements in outcomes. It was queried whether the indicator should focus on people under 75 or 85 years. It was also queried why IND2022-142 included a higher ACR threshold for people with co-existing diabetes than for those without diabetes.

Attendees were asked whether the indicators should focus on provision of Dapagliflozin as it is the only SGLT2i licensed for CKD. It was felt that any indicator would have to monitor provision of all SGLT2i because patients may be on other SGLT2i for other indications.

Attendees were asked whether they agreed with focussing on CKD stage 3a to 5 only, even though SGLT2i could be provided for people at earlier stages. It was thought that this was a pragmatic approach as there would be a substantially larger number of patients with CKD stage 2, coding is poor and there is a lower risk of progression.

Workload implications

Concerns were raised around unacceptable workload implications related to time needed to discuss the risks and benefits of SGLT2i, and the continued monitoring required. Annual ACR testing would be required that is not currently consistent across general practice. It was felt that the numbers of patients per practice could be unmanageable.

Attribution

Attendees reported less familiarity with the provision of SGLT2i for CKD in primary care. It was suggested that the indicator should instead focus on people with heart failure or diabetes for whom there is more common provision of SGLT2i.

Risks of unintended consequences

Concerns were raised around the long-term use and that the indicator would not promote medication review or medicines optimisation.

Attendees noted that the construction of the indicator searches for the last ACR recorded, irrespective of the date. Concerns were raised around low levels of ACR testing and that this indicator may therefore not give an accurate reflection of the true potential denominator.

There was uncertainty whether SGLT2i could improve ACR. If so, some patients would be excluded from the denominator even though they had originally been above the threshold and had benefited from treatment.

Summary

Most attendees did not feel that use of SGLT2i for CKD was common in general practice and the indicator risked over treatment in some populations. Concern also related to workload implications. Most participants did not feel that an indicator on provision of SGLT2i for people with CKD was appropriate for use in an incentivised framework such as the QOF at this time.

Appendix 1: Focus group composition

Table 1: Attendee practice deprivation

Practice deprivation decile	Count of attendees
1-3	0
4-7	6
8-10	3

1 is the most deprived decile, 10 the least deprived decile.

Table 2: Attendee practice list size

Practice list size	Count of attendees
Less than 8000	2
8000 to 10999	2
More than 11000	5

National average list size 2021/22 = 9294

Table 3: Attendee practice QOF achievement 2021/22

Practice achievement	Count of attendees
Less than 580	3
580 to 620	2
More than 620	4

Total points available: 635 (national average practice achievement: 582)

Table 4: Attendee region

Region	Count of attendees
East of England	0
London	1
Midlands	1
North East and Yorkshire	4
North West	1
South East	1
South West	1