Comments form – Consultation on NICE indicators

Deadline for comments: Wednesday, 5pm 06 May 2026
Please return to: indicators@nice.org.uk

We would like to hear your views on new draft NICE indicators for:

- Acne: lymecycline combination therapy
- Acne: long term antibiotic use
- Pain: Annual review long term opioid use
- Pain: Strong opioid use (MSK)
- Pain: Strong opioid use (osteoarthritis and chronic low back pain)
- Diabetes: metformin, SGLT2 inhibitors and semaglutide (T2DM and CVD)
- Diabetes: metformin and SGLT2 inhibitors (early onset T2DM)
- Diabetes: metformin and SGLT2 inhibitors (T2DM)

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 note that there are specific questions for some indicators which you may wish to comment on. 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.

Requirement	Response
Organisation name – Stakeholder or respondent (if you are responding as an individual rather than a registered stakeholder please leave blank):	Royal College of General Practitioners
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:	Adrian Hayter
Type	[office use only]

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Comment number	Indicator ID	Comments Insert each comment in a new row. Do not paste other tables into this table, because your comments could get lost – type directly into this table.
1	GID-IND10347	The principle behind this indicator is sound; efforts to reduce prescribing of strong (or even weak) opiates for long term pain are welcomed. We do, however, think this will be problematic to implement for a number of reasons: 1) The coding of lower back pain is unlikely to be able to differentiate between acute and chronic and, if chronic, we'd be looking at historical coding which may not be the reason for the opiate prescription in the current period. We think that linking of prescriptions to indications is not routine and opiates may be used (appropriately or inappropriately) for many indications, so we believe this indicator may struggle to get a decent denominator. 2) The problem with looking at long term pain is that we're not really looking at pain management any more, we're looking at opiate dependence, and deprescribing in this group is challenging and takes a lot of time and effort. There is very little support for patients and clinicians to facilitate withdrawal from prescribed medications. 3) We don't see much rationale for including tramadol, but not codeine 4) Most patients who are prescribed strong opiates for pain conditions are started on these by pain clinics or after admission to hospital. In response to specific questions: **5. Should the population for this indicator be limited to adults (age 18 years and over)?** We think so, yes. **6. Should prescribing strong opioids for cancer pain be excluded as they can be an appropriate treatment option?** Yes **7. Is it likely that people with osteoarthritis or chronic low back pain will be prescribed opioids for other reasons?** We think it will be difficult to identify the indication from the coded medical record (as above) and most patients in this situation will really be on opiates due to dependence rather than the pain syndrome that lead to initiation. **8. Is it likely that this indicator will inappropriately include patients whose chronic low back pain has resolved?** This is a possibility (as mentioned above).
2	GID-IND10346	This indicator has similar problems to the last one, but the coding will be even more problematic. Even if someone works with CPRD data, it is difficult to identify a helpful denominator from the coded record. In summary, we don't think either of these two indicators are workable. If we were to propose an alternative, we would look at tackling people being started on long term opiates for pain syndromes. We believe stopping people becoming tolerant and dependant in the first place is key.
3	GID-IND10345	We think that this indicator is very reasonable and may be helpful. We support personalised care adjustments, but in this case we don't think people should be able to decline a medication review for opiates, thereby essentially forcing the prescriber to continue without review. Equally, if a patient does not attend multiple invites, then the prescriptions could, and perhaps, should be stopped on safety grounds until a review is undertaken.
4	GID-IND10350	In response to the question: **14. Is there likely to be a significant population who would need to be excluded from measurement using personalised care adjustments (PCAs)because:**

		Yes, we think this is a problem. We think that the indicator, as written, would influence decision making to reduce patient choice. We feel patients would be pressured into taking both medications then they may not need or want them, particularly newly diagnosed patients who would like to focus on lifestyle first, or elderly patients where tight A1c control is not beneficial. **15. This draft indicator does not exclude people with moderate or severe frailty, unlike a number of current QOF indicators for diabetes (see indicators on BP, HbA1c and statins / LLT). We propose to use PCAs instead. Is this the right approach for frailty?** We don't think this is the correct approach. We think clinicians worry about using PCAs and frail patients will end up being over treated. We would propose excluding people with frailty.
5	**GID-IND10349**	Similar to the above, whilst we can see the intention of this, it is a broad brush approach that we think will potentially overmedicalise some people who may want to focus on lifestyle changes (that may put them into remission).
6	**GID-IND10348**	Once again, we really think these indicators are an overreach of QOF by railroading decision making in this area. Although PCA's exist, in reality people will be managed in an increasingly protocolised way, reducing clinical judgement (and skill) and personalised care. We think it's a retrograde step. People with frailty should be excluded.
7	**GID-IND10343**	Overall, this seems like a low impact indicator in the grand scheme of things. In response to questions: 22. Yes, not all patients will be on lymecycline, either due to tolerance, choice or rotation of antibiotic. We think it would be best to include dox and we don't see a problem with this. 23. Long term antibiotics for other indications is not common. We would suggest having an exception reporting code stating that 'this patient is not suitable for {the indicator}' so clinicians can identify and exclude anyone included in the denominator who shouldn't be. 24. Yes, we do recommend OTC Rx sometimes, but we think this is unlikely to be a major problem. Usually, by the time we're on step 2 or 3 treatment patients are prescribed the treatments. 25. Potentially. We don't see any harm in including it as some patients may not get on with azelaic acid or adapalene.

Insert extra rows as needed

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 the NICE website.

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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