# National Institute for Health and Care Excellence

**Indicator Advisory Committee**

**Date: Tuesday 4 June 2019**

**Location:** NICE office, Level 1a City Tower, Piccadilly Plaza, Manchester, M1 4BT

**Attendees**

**Indicator Advisory Committee members:**

Daniel Keenan (DK) [chair], Andrew Black (AB) [vice chair], Linn Phipps (LP), Mary Weatherstone (MW), Elena Garralda (EG), Dominic Horne (DH), Ronny Cheung (RC), Richard Garlick (RG), Tessa Lewis (TL), Nigel Beasley (NB), Chris Gale (CG), Chloe Evans (CE), Victoria Welsh (VW), Waqas Tahir (WT), Liz Cross (LC), Michael Bainbridge (MB) and Tim Cooper (TC)

**NICE attendees:**

Craig Grime (CDG), Mark Minchin (MM), Theresa Jennison (TJ), Daniel Smithson (DS), Eileen Taylor (ET) and Ania Wasielewska (AW)

**NICE Working Groups for review of QOF indicators:**

Andrew Green (AG)

**National Collaborating Centre for Indicator Development (NCCID):**

Paula Whitty (PW) and Andrea Brown (ABr)

**NHS Digital:**

Gemma Ramsay (GR) and Ross Ambler (RA)

**NICE observers:**

Trudie Willingham and Sarah Winchester

**Apologies:**

Rachel Brown, Allison Streetly and Kate Francis

**Item 1 - Outline of the meeting**

The Chair welcomed the attendees and the indicator advisory committee (IAC) members introduced themselves. Introductions were made for the six new IAC members. The Chair informed the committee of the apologies received and went through the planned business of the day.

**Item 2 - NICE advisory body declarations of interest**

Additional declarations of interest which had arisen since the register was circulated were shared with members:

Waqas Tahir: Received consultancy advisory fees from a pharmaceutical company, however, this was not relevant to the topics under discussion today.

Andrew Black: Undertaken paid advisory work for a national broadcaster in connection with a legal case concerning the QOF. There was no direct link to the discussions at IAC and the period to which the case related was a time when AB was not a member of IAC.

All other declarations were included on the register as circulated.

**Item 3 - Review of minutes and actions of December 2018 committee**

The minutes were approved as an accurate record. TJ informed the committee that the actions from the December 2018 meeting had all been progressed.

PW updated the committee on 2 actions which were outstanding from previous meetings:

* December 2016 – further testing of indicators for people with psychosis. The data source for the indicators had been proposed to be the national audit for clinical psychosis. As the audit had been amended to focus on early intervention in psychosis the data are no longer available.
* August 2018 – alcohol specialist services – potential outcome indicators: Following discussions with PHE and the National Drug Treatment Monitoring System team it was noted that PHE’s view was that the most suitable place for such an indicator, if it were to be developed, was the Public Health dashboard. PHE concluded that this indicator would not be suitable for inclusion in the dashboard as there was little change from year to year and not much variability across the country.

**Item 4 - NICE Indicator programme: general update**

MM provided a general update on aspects of the indicator programme that were not being covered today or at tomorrow’s meeting. MM updated the group on NICE’s work updating the current indicator process guide noting that draft guide is out for public consultation.

LP requested that the 3rd bullet point under the importance domain of the indicator assessment criteria included in the draft guide be revised to refer to patient outcomes.

**Action:** TJ to record this in responses to the consultation.

It was noted that where under and over treatment were referred to this should be only where relevant.

It was queried at which stage of the process the assessment criteria would be applied. CDG advised that the intention is to use them throughout the development process. The criteria could also be applied retrospectively but this would be a lengthy process and applicable to indicators in national frameworks initially.

**Action:** TJ to circulate NEJM MacLean et al. 2018 paper.

**Item 5 - Indicators development: consultation and piloting – Introduction**

MM introduced the committee to the work that has been completed for the review of the asthma, COPD and heart failure QOF indicators and explained the development history. MM noted that the current indicators for these three clinical areas had been reviewed and updated by working groups that included representation from a range of national organisations including NHS England, NICE and the BMA’s GPC alongside topic experts from the relevant NICE guidelines.

**Item 5a – Indicator development: Asthma**

DS presented a summary of the stakeholder consultation feedback for the draft asthma indicators along with additional background information.

IND63: The contractor establishes and maintains a register of patients with asthma aged 5 or over.

Key themes from consultation:

* Support for removal of exclusion criteria and use of lower age limit
* Concern that people with suspected asthma might be missed
* Concern of the resources needed to identify the correct patients / people that should be excluded coming back on the register

The committee was asked to consider the following:

* Effects of including a minimum age of 5 for the register
* Impact on resources
* Should this be included on the NICE menu as a general practice level indicator?

The committee noted that adding the 5 year lower age limit should not prevent the management and care of children with suspected or confirmed asthma aged under 5. There was a potential additional workload in determining if those patients previously excluded as not having had drugs prescribed within the previous 12 months had asthma, but it was noted this would generally be limited to a one year impact.

**Action:** The committee agreed that IND63 should progress to the NICE menu.

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.

Key themes from consultation:

* Support for use of objective tests to confirm diagnosis
* A mixed reaction to the tests recommended
* Suggestion to adapt and align more closely to the diagnostic algorithm in the NICE guideline (NG80)
* Issues around staff training and accessibility to certain tests
* A recommendation for retrospective testing

The committee was asked to consider the following:

* Further alignment to NG80 diagnostic algorithm or inclusion of additional tests
* Accessibility to tests including equipment
* Retrospective testing
* Should this be included on the NICE menu as a general practice level indicator?

The NICE guideline for asthma (NG80) recommends the use of at least 2 tests for confirmation of the asthma diagnosis. The committee agreed that the indicator should more closely align with the guideline.

**Action:** The committee requested revision to the wording of IND64 to require a record of spirometry and another objective test (e.g. FeNO, reversibility or variability) before the indicator should progress to the NICE menu. NICE to review when the asthma guideline is updated

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.

Key themes from consultation:

* Support for using a validated questionnaire, short acting beta-agonist (SABA), recording exacerbations and written action plans
* Concern about increased consultation time
* Suggestions for increased scope
* Suggestions for increased frequency

The committee was asked to consider:

* Impact on consultation time
* Increasing scope: Use of SABA canisters, occupational asthma, inhaler technique, oral corticosteroid (OCS) prescriptions and medicines inheritance
* Frequency of assessments
* Should this be included on the NICE menu as a general practice level indicator?

It was agreed to include the requirement for the personalised action plan to be ‘agreed with the patient’ in the supporting guidance for the indicator, to promote quality in the conversation between the patient and healthcare professional (HCP).

Definitions of exacerbations should be in line with national audits for asthma.

**Action:** The committee agreed that IND65 should progress to the NICE menu

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.

Key themes from consultation:

* Support for asking patients about smoking status and increasing opportunities for advice
* Possibility for wider scope: other substances (incl vaping and shisha), referrals, objective testing
* Concern about asking younger children
* Suggestion for only including second-hand smoke exposure in the home
* Suggestion to split indicator in to active and passive

The committee was asked to consider:

* Increasing the indicator scope to include inhaling other substances than tobacco, referral to smoking cessation services or advice, objective testing
* Making the indicator more specific regarding age and setting of second-hand smoke exposure
* 2 separate indicators for smoking and exposure to second-hand smoke
* Should this be included on the NICE menu as a general practice level indicator?

The committee decided to keep the focus on tobacco smoke but ask about passive exposure both within the home and outside the home.

**Action:** The committee agreed that IND66 should progress to the NICE menu.

**Item 5b – Indicator development: COPD**

DS presented a summary of the stakeholder consultation feedback for the COPD indicators review, along with additional background information.

IND67: 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.

Key themes from consultation:

* Support for reduction in time to diagnosis and treatment, and inclusion of objective guidance for GPs and staff involved in spirometry
* Concern about supply of spirometers and timescale/workload
* Concern about patients with other diseases being removed from follow ups based on spirometry
* Suggestion to use the lower limits of ‘normal’ to quantify airflow obstruction

The committee was asked to consider:

* Supply of spirometry equipment
* Impacts on workload
* Impacts in patients with other pre-existing diagnoses
* Should this be included on the NICE menu as a general practice level indicator?

**Action:** The committee agreed that IND67 should progress to the NICE menu.

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.

Key themes from consultation:

* Support for including number of exacerbations, more information for clinicians, benefits to patients
* Concerns about difficulty monitoring exacerbations and variability in definition
* Concerns around over recording of exacerbations and associated prescribing
* Suggestion of additional breathlessness referral tools

The committee was asked to consider:

* Definitions of exacerbations and how to identify them
* Impact on corticosteroid prescription
* Should other breathlessness referral tools be included in this indicator
* Should this be included on the NICE menu as a general practice level indicator?

GR confirmed that there was a code in place to record exacerbations for COPD. The committee noted that this would not impact on workload as these patients were already being seen.

**Action:** The committee agreed that IND68 should progress to the NICE menu.

**Item 5c – Indicator development: Heart Failure**

AW presented a summary of the stakeholder consultation feedback for the heart failure indicators review, along with additional background information.

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.

Key themes from consultation:

* General support for tightened timeframe
* Comments around timely access to echocardiogram
* Concerns about cost and time pressure within practice
* Suggestion that NT-proBNP testing should be included in the diagnostic pathway.

The committee was asked to consider:

* Potential for increased costs and time pressure
* Including NT-proBNP for diagnosis
* Potential to improve patient outcomes by facilitating earlier diagnosis.

The committee noted general support for reducing the timeframe. The committee was aware that personalised care adjustments could be used to record issues in accessing echocardiograms in the specified timeframes and noted that these data could be used to record variations in access across localities. The committee discussed stakeholders’ suggestions that NT-proBNP testing should be included. Whilst aware that NT-proBNP was recommend in the NICE guideline (NG106) the committee decided that the indicator should focus on echocardiography as this was the objective test to diagnose heart failure.

**Action:** The committee agreed that IND69 should progress to the NICE menu.

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.

Comments from consultation:

* General support for the indicator
* Concern about the difficulty of using 2 terms: left ventricular systolic dysfunction (LVSD) and heart failure with reduced ejection fraction (HFrEF)
* Lack of clarity on terminology may result in patients not being managed appropriately.
* Suggestion that ARNI (Sacubitril valsartan) should be specifically highlighted in addition to ACE-I and ARB.

The committee was asked to consider:

* Potential for over-treatment and misalignment with NICE guidance when referring to people with LVSD as opposed to people with HFrEF
* Potential for unintended consequences if the indicator solely focused on people with HFREF as defined by NICE guidance
* Including treatment with ARNI alongside ACE-I and ARB.

The committee discussed the cohort of people with heart failure which should be included in the indicator. The committee was aware that NICE guidance (NG106) recommends first-line treatment with ACE and a beta-blocker for people with HFrEF of less than 40%. The committee heard that people with LVSD may include a proportion with HFrEF between 40% and 50%, this subset of people with heart failure sits outside of the recommendations in NG106.

The committee heard that the current coding of heart failure in general practice is generally undertaken using LVSD rather than HFrEF and was aware that making HFrEF a requirement to meet the indicator would mean that people with heart failure and a historic coding of LVSD would be removed from this treatment indicator.

The committee discussed whether the indicator should explicitly reference use of an angiotensin receptor-neprilysin inhibitor (ARNi). It was noted that valsartan is already included in the business rules as an ARB. Patients on valsartan are therefore included in the ruleset. The committee also discussed an indicator focussed solely on ARNi use and concluded that it would not be appropriate given the small numbers and concern about the attribution of responsibility given initiation by specialists.

**Action:** The committee agreed that the existing NICE indicator (NM89) should remain on the NICE menu but with supporting guidance that encouraged the use of HFrEF in line with NICE guidance.

**Action:** NICE to examine the average number of patients per practice if the denominator was only patients with HFrEF, in order to review whether the indicator is viable at practice level.

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.

Key themes from consultation:

* Strong support for prescribing beta-blockers for people with heart failure due to LVSD rather than the subgroup already prescribed ACE-I/ARB
* concern about the difficulty of using 2 terms: LVSD) and HFrEF
* suggestion that separating the indicator for treatment with beta-blockers from co-prescribing with ACEi/ARB could slow the achievement of optimal patient therapy

The committee was asked to consider:

* Potential for over-treatment and misalignment with NICE guidance when referring to people with LVSDs as opposed to people with HFrEF
* Potential for unintended consequences if the indicator solely focused on people with HFrEF as defined by NICE guidance

The committee noted the same issue with the denominator for this indicator as detailed for IND70. The committee were aware of the support for this indicator and noted that the current QOF indicator incentives the prescribing of beta blockers if the person is already treated with ACE-I or ARB. The committee was also aware that they had agreed to leave NM89 on the NICE menu.

**Action:** Recognising that it was agreed that indicator NM89 would remain on the NICE menu the committee asked the NICE team to further explore the development of this indicator.

**Action**: NICE to examine the average number of patients per practice if the denominator was only patients with HFrEF, in order to review whether the indicator is viable at practice level.

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.

Key themes from consultation:

* support for an indicator that would facilitate regular reviews of functional capacity and medication in people with heart failure
* suggestion that review should be carried out every 6 months in line with NICE guidance
* suggestion that the proposed wording may be misinterpreted; alternative wording suggestion:

*The percentage of patients on the register with heart failure, who had a review undertaken by a healthcare professional in the preceding 12 months, including an assessment of functional capacity (using the New York Heart Association classification) and a review of medication.*

The committee was asked to consider:

* Practicalities of measuring 6 monthly reviews.
* Opportunities to improve patient outcomes by optimising medication

The committee discussed the inclusion of optimisation of medicines within the supporting guidance for the indicator as part of the medicines review. The term healthcare professional should be removed to bring the wording of the indicator in line with others on the NICE menu. The committee was aware that the NICE guideline recommended 6 monthly reviews but decided to leave this as annual review.

**Action:** The committee agreed to progress IND72 to the NICE menu. The committee asked that NICE included optimisation of medicines in the supporting guidance.

**Item 5d – Indicator development: consultation and piloting – Piloting methodology**

PW presented the next set of indicators for discussion to the committee and explained the process that NEQOS have taken for their piloting.

**Item 5e – Indicator development: Multimorbidity and frailty**

ABr presented the outcome of the piloting process. ET presented a summary of the stakeholder consultation feedback for the multimorbidity and frailty indicators review, along with additional background information.

Indicator 1: Multimorbidity register **–** The practice can produce a register of people with multimorbidity who would benefit from a tailored approach to care. (Where, for the purposes of the pilot, patients with multimorbidity are defined as those with 4 or more condition clusters supplemented by clinical judgement).

Key themes from consultation:

* Use of the multimorbidity index will have a positive impact for earlier detection and management.
* Support for a template that can be shared and adapted.
* Frailty is missing from these indicators.
* The correct IT tools are needed to capture this information including linking to the patient’s registration on the frailty register.
* The proposed ‘scoring system’ would identify extremely large numbers of patients.
* Large number of comments were received on the conditions included and omitted from the register.
* Unclear what a ‘tailored approach to care’ would mean in practice.

The committee was asked to consider:

* The merit of revising the list of conditions included in the register.
* The overlap between this register and the current data collection for frailty in people aged 65 years and above included in the GMS contract.
* Concerns over the size of the population identified by the proposed register.
* Suggestions that a template could be shared and adapted at a local level.
* Uncertainty of what a ‘tailored approach to care’ would mean in practice.
* Should this be included on the NICE menu as a general practice level indicator?

The committee discussed previous decisions to use 4 or more condition clusters as a definition of multi-morbidity, even though the NICE guideline proposes 2 or more long term conditions. PW reminded the committee that this definition had been selected in order to ensure a manageable and practical cohort size and it was noted that 70% of practices within the pilot supported the introduction of the indicator. For clarity, the committee suggested amending any accompanying documentation to highlight that the indicators focussed on ‘severe multimorbidity’ to reflect the use of clusters. It was also noted that a comparison with work published by the Health Foundation in 2018 should be undertaken.

**Action:** ET to consider amendments to the accompanying guidance to clarify that the indicator applies to people with severe multimorbidity.

Indicator 2: Frailty register – people with moderate or severe frailty

The practice can produce a register of people with moderate or severe frailty, defined as those patients who have been diagnosed using an appropriate tool and applying clinical judgement (in accordance with the GP core contract data collection).

Key themes from consultation:

* Frailty is a good indicator for likelihood of hospital admission and risk of deterioration of overall health and outcomes.
* Generally, widely supported.
* Concern about how frailty will be measured and quantified.
* The correct tools must be used to implement this change.
* Incorporate nutritional screening, assessment and management into frailty pathways.
* Include mild frailty in the register in future, to support practices to reduce progression of frailty in patients.

The committee was asked to consider:

* The committee is asked to note that the data required to underpin this indicator are already being collected.
* Should this be included on the NICE menu as a general practice level indicator?

The committee was aware that the 2017/18 GP contract introduced a requirement for practices to identify people with moderate and severe frailty.

**Action:** The committee agreed that indicator 2 should progress to the NICE menu.

Indicator 3 – Structured medication review

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 has taken place as a shared discussion.

Key themes from the consultation:

* Regular medication reviews mean greater consideration of different conditions and the impact treatment has on care and wellbeing and should reduce polypharmacy.
* Shared discussion is an opportunity for healthcare professionals to have a wider conversation about an individual’s needs, circumstances and health.
* This is sensible because both groups of patients are covered by one indicator.
* Wording does not include the importance of deprescribing.
* Use of a “recognised tool” is vague.
* Focus on medication review may distract from holistic conversations about care.

The committee was asked to consider:

* If examples of recognised tools should be given.
* How the indicator can decrease the likelihood of harm from overtreatment through emphasizing the importance of deprescribing.
* Should these be included on the NICE menu as general practice level indicators?

The committee agreed that it would be helpful to describe the tools which could be used and to allow practitioners a choice in which tool to use. The aspect on shared decision making was supported and it was noted that this was an area in which use of innovative technology could be explored.

**Action:** The committee agreed that Indicator 3 should progress to the NICE menu.

Indicator 4 – falls prevention

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 preceding 12 months.
* And, if at risk, have been provided with advice and guidance with regard to falls prevention (in the preceding 12 months).

Key themes from the consultation:

* This indicator is strongly supported
* People with moderate frailty are the single largest identifiable patient group who will benefit from falls prevention interventions and may not be currently engaged.
* Align with the wording in the GMS contract.
* Collecting data on patients at risk of falling is valuable but professionals should be trusted to act when risks are identified.
* Does this record whether the question has been asked in the past 12 months, or the number and type of falls in that time?
* Include nutritional screening, assessment and management in falls pathways.

The committee was asked to consider:

* Stakeholder comments that patient or carer recall of the number and type of falls is likely to be poor, resulting in poor quality data.
* Whether the wording should align more closely with the GMS contract, for people with severe frailty “the number of patients with severe frailty who are recorded as having had a fall in the preceding 12 months”.
* Should this be included in the NICE indicator menu?
* Is it suitable for incentivisation with a national pay-for-performance framework?

The committee noted that this indicator may be more appropriate as part of local integrated care initiatives but agreed that the role of primary care was to recognize people at risk and signpost to other services. The indicator would be better expressed as two separate indicators.

**Action:** The committee agreed that Indicator 4 should be split into two indicators and both should progress to the NICE menu.

**Item 6 – Review of decisions**

This item was deferred to the following day.

**Close of meeting**