# National Institute for Health and Care Excellence

### Indicator Advisory Committee

**Date: Wednesday 5 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), Elena Garralda (EG), Allison Streetly (AS), 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), Rick Keen (RK), Eileen Taylor (ET) and Sabina Keane (SK)

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

Paula Whitty (PW) and Andrea Brown (ABr)

**NHS Digital:**

Gemma Ramsay (GR)

**NICE observers:**

Sarah Winchester and Jamie Jason

**Apologies:**

Rachel Brown, Kate Francis, Theresa Jennison and Mary Weatherstone

**Item 1 - Outline of the meeting**

The Chair welcomed the attendees and the indicator advisory committee (IAC) members introduced themselves. The Chair informed the committee of the apologies 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:

Nigel Beasley – had recently set up a small brewery of which he is co-director.

**Item 3 – Indicator development: HIV testing**

ABr presented the outcome of the NEQOS piloting process and ET presented a summary of the NICE stakeholder consultation feedback, with additional background information.

**Indicator 1: HIV testing in newly registered patients**

The percentage of adults and young people newly registered with a GP in an area of high or extremely high HIV prevalence who receive an HIV test within 3 months of registration.

**Indicator 2: Annual HIV testing in patients having a blood test**

The percentage of adults and young people at a GP surgery in an area of high or extremely high HIV prevalence who have not had an HIV test in the last 12 months, who are having a blood test and receive an HIV test at the same time.

Key themes from consultation:

HIV testing in newly registered patients:

* Is this population screening?
* Need for more evidence on groups who would benefit.
* Requires discussion with sexual health services who commonly test and manage.
* There may be unintended consequences and implications in primary care.
* Disagree with use of high and extremely high prevalence areas.

Annual HIV testing when having a blood test:

* Concept of using defined high and extremely high prevalence areas to focus testing.
* The ability of primary care staff to provide an appropriate level of advice on the diagnosis, treatment and potential infection transfer for HIV compared to sexual health infections they routinely see in primary care.

The committee was asked to consider the following:

* If the indicator represents population screening
* Could the target population be refined further?
* The use of high and extremely high prevalence areas to identify the eligible population
* The ability to normalise HIV testing in primary care
* The potential for unintended consequences:
* resource and training implications
* the impact on sexual health services
* Should these be included on the NICE indicator menu to support implementation of the guidance in select geographical areas only?

The committee heard that GPs in high prevalence areas of HIV were now experienced in dealing with this issue and that IND1 would be especially important for these practices, but there are implementation and resource barriers present for example insufficient numbers of translators. The committee recognised the importance of the National Screening Committee (NSC) and it’s view on these indicators particularly as stakeholders noted concerns that this may be population screening. MM noted that NICE and the NSC are discussing this now.

**Action:** The committee agreed that indicator 1 and 2 should progress to the NICE menu as indicators specific to these geographical areas to help support implementation of NICE guidance – they are not suitable for a national performance framework. NICE to confirm the outcome of discussions with the NSC and to explore development of additional implementation support to facilitate use of the indicators.

**Item 3b – Indicator development: Alcohol**

PW presented the outcome of the NEQOS piloting process for the alcohol screening indicators review. SK presented a summary of the NICE stakeholder consultation feedback for the alcohol screening indicators review, along with additional background information.

It was agreed that the committee would review the 3 alcohol ‘screening’ indicators first and then review the 3 intervention indicators. The committee noted that the term ‘screening’ whilst consistent with the FAST and AUDIT-C tools was potentially misleading and may have resulted in stakeholders raising concerns that these indicators contradicted NSC guidance.

**Alcohol screening and assessment indicators**

**Indicator 1: Alcohol screening for newly diagnosed hypertension patients**

The percentage of patients with a new diagnosis of hypertension in the preceding 12 months who have been screened for unsafe drinking using the FAST or AUDIT-C tool in the 3 months before or after the date of entry on the hypertension register.

Key themes from consultation:

* Tools in combination with hypertension management were supported
* Concern about the term ‘unsafe’ drinking
* Small indicator denominators at individual GP practice level
* Familiarity of the tools in GP practices
* The burden of introducing alcohol screening tools for newly diagnosed hypertension
* National Screening Committee does not currently recommend screening for alcohol use.

The committee was asked to consider:

* Use of the term ‘unsafe’
* Stakeholder concerns about patient numbers:
	+ small indicator denominators at individual GP practice level
	+ burden of work for general practice
* Knowledge of the two tools and access to the tools in GP IT systems
* Concerns around contradicting guidance from the NSC
* Should this be included on the NICE menu as a general practice level indicator?

**Indicator 3: Alcohol screening for patients with a new diagnosis of depression or anxiety**

The percentage of patients with a new diagnosis of depression or anxiety in the preceding 12 months who have been screened for unsafe drinking using the FAST or AUDIT-C tool in the 3 months before or after their diagnosis being recorded.

Key themes from consultation:

* The term ‘unsafe’ drinking is not appropriate
* Introducing additional structured tools into a depression assessment may detrimentally affect the GP’s and patient relationship
* These tools at practice level are not currently expected in IAPT services
* The tools’ length could be burdensome
* Whether GPs would feel comfortable asking about alcohol use
* The evidence base for the 3 months before or after timescale
* The need to ensure the indicator does not detract practices from referring individuals onto IAPT services. This is a priority in the Long Term Plan.

The committee was asked to consider:

* Stakeholder concerns around patient numbers:
	+ - small indicator denominators at individual GP practice level
		- burden of work for general practice
* Whether discussions about alcohol use are already standard practice
* GP confidence in asking about alcohol
* The evidence base for the timescale – why 3 months?
* The suggestion this has the potential to detract referrals to IAPT services
* Should this be included on the NICE menu as a general practice level indicator?

**Indicator 6: Alcohol screening for patients with CHD, atrial fibrillation, chronic heart failure, stroke or TIA, diabetes or dementia**

The percentage of patients with one or more of the following conditions: CHD, atrial fibrillation, chronic heart failure, stroke or TIA, diabetes or dementia who have been screened for unsafe drinking using the FAST or AUDIT-C tool in the preceding 2 years.

Key themes from consultation:

* The term ‘unsafe’ drinking, as no level of drinking is ‘safe’
* Implementing the tools for all the conditions is a potential burden. Possibly alleviated with use of templates on GP computer systems and members of the GP multidisciplinary team doing assessments
* Whether it is clinically inappropriate to use these screening tools in people diagnosed with dementia as memory loss is a key symptom of dementia. They questioned if high levels of personalised care adjustments would need to be applied
* The suitability of a 2-year interval for people with dementia, due to its degenerative nature
* The evidence base indicating that people with dementia are likely to drink excess alcohol.

The committee was asked to consider:

* The term ‘unsafe’ drinking
* The burden of implementing screening tools in these long-term conditions
* Appropriateness of using these tools in people diagnosed with dementia
* The inclusion of people with dementia and the timescales used
* Should this be included on the NICE menu as a general practice level indicator?

The committee noted that the term ‘unsafe drinking’ was outdated, and that the recommended tools use the term ‘hazardous drinking’. It was agreed that the terminology should be amended in line with Public Health England guidance.

The committee discussed the potential limitations of using FAST and AUDIT-C tools as using the templates can be a distraction for the healthcare professional and intrusive to patients. It was noted that the tools can help start a conversation about alcohol use. Further GP training may be required to use these tools effectively.

**Action:** The committee agreed to progress all three indicators to the NICE menu, with additional rationale added to Indicator 6 stating that screening did not need to take place at the first consultation. The term ‘unsafe drinking’ also needs to be amended in line with Public Health England guidance.

**Alcohol brief intervention indicators**

PW presented the outcome of the NEQOS piloting process for the alcohol brief intervention indicators review. SK presented a summary of the NICE stakeholder consultation feedback for the alcohol brief intervention indicators review, along with additional background information.

**Indicator 2: Alcohol brief intervention for newly diagnosed hypertension patients**

The percentage of patients with a new diagnosis of hypertension in the preceding 12 months with a FAST score of ≥3 or AUDIT-C score of ≥5 who have received brief intervention to help them reduce their alcohol related risk within 3 months of the score being recorded.

Key themes from consultation:

* Concerns that it is not clear if the aim is brief advice given within the 3 months screening window or a reduction in drinking seen within 3 months of brief advice
* The burden of providing brief intervention compared to the benefits.

The committee was asked to consider:

* Does the indicator wording need amending to be clear we are measuring provision of the brief intervention rather than reduction in alcohol consumption?
* Stakeholder concerns around the clinical benefits versus the burden.
* Should this be included on the NICE menu as a general practice level indicator?

**Indicator 4: Alcohol brief intervention for patients with a new diagnosis of depression or anxiety**

The percentage of patients with a new diagnosis of depression or anxiety with a FAST score of ≥3 or AUDIT-C score of ≥5 who have received brief intervention to help them reduce their alcohol related risk within 3 months of the score being recorded.

Key themes from consultation:

* Whether the brief intervention should be within 3 months of the AUDIT-C or FAST screening tools, or whether the aim of the intervention should be to help them reduce their drinking within 3 months
* Additional structured tools may affect the GP’s ability to build rapport and undertake a holistic patient-centred approach
* The indicator’s focus on alcohol consumption and its lack of consideration of how specific illnesses may affect this intervention or ability for individual to complete this intervention
* intervention should be offered sooner
* The definition of brief intervention needs further clarity, and guidance is needed on how exception reporting could indicate patient choice in declining the intervention.

The committee was asked to consider:

* Does the indicator wording need amending to be clear we are measuring provision of the brief intervention?
* The impact of introducing structured tools on providing a patient-centred approach
* The timeframe between screening and intervention – why 3 months? Suggestion that the intervention should be provided sooner
* Suggestion that a clear definition of brief intervention should be provided
* Should this be included on the NICE menu as a general practice level indicator?

**Indicator 5: Alcohol brief intervention for patients with schizophrenia, bipolar affective disorder and other psychoses**

The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses with a FAST score of ≥3 or AUDIT-C score of ≥5 who have received a brief intervention to help them reduce their alcohol related risk within 3 months of the score being recorded.

Key themes from consultation:

* The Lester Tool as a method of alcohol screening supports staff in general practice to have a discussion with people with SMI on the use of brief intervention following screening.
* The timing for receipt of the brief intervention
* The delay in offering the intervention post screening
* The definition of brief intervention.

The committee was asked to consider:

* Does the indicator wording need amending to be clear we are measuring the time to provision of the brief intervention?
* The impact of other illness on the intervention
* Time between screening and intervention offer
* Suggestion that a clear definition of brief intervention should be provided
* Should this be included on the NICE menu as a general practice level indicator?

**Indicator 7: Alcohol brief intervention for patients with CHD, atrial fibrillation, chronic heart failure, stroke or TIA, diabetes or dementia**

The percentage of patients with one or more of the following conditions: CHD, atrial fibrillation, chronic heart failure, stroke or TIA, diabetes or dementia who have been screened for unsafe drinking using the FAST or AUDIT-C tool in the preceding 2 years.

Key themes from the consultation:

* The focus on alcohol consumption and lack of consideration of how specific illnesses may affect this intervention or ability for individual to complete this intervention
* Offering the brief intervention up to 3 months after screening, intervention should be offered sooner
* The definition of brief intervention needs clarification
* A stakeholder suggested the brief intervention could be focussed on the carers of people with dementia as they felt the intervention was not always appropriate for use in people suffering from memory loss.

The committee was asked to consider:

* If specific illnesses may affect this intervention or ability for individuals to complete the intervention
* The timeframe for offering brief intervention
* The impact of introducing structured tools on providing a patient-centred approach to care
* Appropriateness of use in those with memory loss.
* Should this be included on the NICE menu as a general practice level indicator?

The committee highlighted that all four interventions have the potential impact to improve quality care.

The committee discussed the NICE consultation feedback on brief intervention for patients with long-term conditions. It was clarified that the intervention could occur within three months.

**Action:** The committee agreed to progress all four indicators to the NICE menu. However, given the small denominator size for the serious mental illness indicator, NICE will highlight that this is not suitable for inclusion in the QOF.

**Item 3c - Indicators development: Familial hypercholesterolemia (FH)**

**Diagnosis of FH indicators**

ABr presented the outcome of the NEQOS piloting process for the FH diagnosis indicators review. SK presented a summary of the NICE stakeholder consultation feedback for the FH diagnosis indicators review, along with additional background information.

**Indicator 1: Assessment of patients aged 29 years and under with a high total cholesterol**

The percentage of people aged 29 years and under, with a total cholesterol concentration greater than 7.5 mmol/l that are assessed against the Simon Broome or Dutch Lipid Clinic Network (DLCN) criteria

Key themes from consultation:

* Supported to improve early FH identification, referral and treatment rates and will have a significant impact on reducing mortality and morbidity
* Substantial burden to primary care with limited clinical benefit
* Small indicator denominators at individual GP practice level negatively impact on the validity of the indicator
* Not approved by the National Screening Committee
* Triglyceride levels will need to be considered as well as high cholesterol. Ideally patients with secondary causes should also be excluded before Simon Broome or DLCN assessment is carried out
* This indicator will require a Read/SNOMED code for assessment by Simon Broome or DLCN criteria, if not already available.

The committee was asked to consider:

* The concerns raised around the burden of testing and links to screening, possible misunderstanding around how the indicator works?
* Stakeholder concerns around patient numbers:
	+ - small indicator denominators at individual GP practice level
		- burden of work for general practice
* Additional assessments for triglycerides and exclusion of secondary causes.
* Codes required for GP systems
* Should these be included on the NICE menu as general practice level indicators?

**Indicator 2: Assessment of patients aged 30 years and older with a high total cholesterol**

The percentage of people aged 30 years and older with a total cholesterol concentration greater than 9.0 mmol/l that are assessed against the Simon Broome or Dutch Lipid Clinic Network (DLCN) criteria.

Key themes from consultation:

* Supports improved diagnosis and treatment rates to prevent premature death.
* Does not support the wider identification of these people
* Substantial burden to primary care with limited clinical benefit
* Small indicator denominators at individual GP practice level negatively impact on the validity of the indicator
* Not currently approved by the National Screening Committee
* Testing lipids for patients aged 30 and over a substantial burden to primary care. Is this proportionate to the benefit to patients?
* Triglycerides and the need to exclude secondary causes of high cholesterol should be considered
* Appropriate coding will be required for GP systems.

The committee was asked to consider:

* Stakeholder concerns around patient numbers:
	+ - small indicator denominators at individual GP practice level
		- burden of work for general practice
* Suggestion to construct one indicator based on Indicator 1 and Indicator 2 for all age ranges to avoid the challenge of small numbers.
* Should this be included on the NICE menu as a general practice level indicator?

The committee highlighted how this is currently standard practice for GPs and the workload for this would not be a problem due to the low patient numbers. It was felt these indicators would aid early diagnosis.

The committee discussed the difference between the 7.5mmol/l and 9.0mmol/l cutoff points. It was noted that relying solely on one indicator at 7.5mmol/l cutoff could potentially lead to workload issues.

**Action:** The committee agreed to progress both indicators to the NICE menu. NICE team to investigate the difference between 7.5mmol/l and 9.0mmol/l cutoff points and the potential to merge together.

**Diagnosed FH indicator**

ABr presented the outcome of the NEQOS piloting process for the diagnosed FH indicator review. SK presented a summary of the NICE stakeholder consultation feedback for the diagnosed FH indicator review, along with additional background information.

**Indicator 3: Referral of patients with a clinical diagnosis of familial hypercholesterolaemia**

The proportion of people with a clinical diagnosis of familial hypercholesterolaemia (FH) referred for specialist assessment.

Key themes from consultation:

* Helps drive identification of people with suspected FH in primary care and ensure appropriate management
* Treating FH with specialist involvement was supported based on the complexity of the condition and its management.
* Clarification needed on which specialist assessment service people with FH should be referred to and what this entails.
* Accuracy of diagnosis coding.
* Measuring referrals without measuring those having genetic testing may add increased cost and little benefit.
* This indicator should be changed from people with a clinical diagnosis of FH who are referred to a lipid or endocrine clinic to those who have been genetically screened as the purpose of the referral to secondary care is to get diagnostic confirmation through genetic testing however this is not current national practice. By April 2020 genomic hubs will come online and this should be the end point.
* Arguably as GPs cannot currently refer FH patients directly for genomic testing the measure in QOF is restricted. Knowing and managing genomic risk is vital.
* It was assumed ‘referred for specialist assessment’ includes phone call assessment. Could this description be expanded to include face-to-face specialist assessment?

The committee was asked to consider:

* Which specialist assessment service people should be referred to
* Accuracy of diagnosis coding
* Focussing on a combined measure of referrals and genetic testing
* The description of specialist assessment.
* Should this be included on the NICE menu as a general practice level indicator?

The committee queried the indicator’s potential to drive improvement and whether referral following a clinical suspicion of FH would be considered standard practice. The committee discussed that gene positive coding and cascade family testing has

yet to be comprehensively implemented in primary care. It was therefore felt that this indicator should not be progressed at this time.

**Action:** The committee agreed not to progress this indicator to the NICE menu but consider as a future CCG level indicator.

**Item 4 – Indicators removed from QOF for 2019/20**

CDG presented information to the committee on the indicators which were retired from the QOF for 2019/20, highlighting the key elements in determining their retirement.

The committee were asked to consider whether the following indicators should remain on the NICE menu, or whether alternative actions were required:

Indicator NM115 (CON003)

**Action:** The committee agreed to keep on the NICE menu but at network level, not as a general practice level indicator.

Indicator NM105 (COPD004)

**Action:** The committee agreed to keep on the NICE menu.

Indicator NM63 (COPD005)

**Action:** The committee agreed to align with NICE guidance.

Indicator NM72 (DEM005)

**Action:** The committee agreed to keep on the NICE menu at network level, not as a general practice level indicator.

Indicator NM20 (MH008)

**Action:** The committee agreed to keep on the NICE menu, at network level, not as a general practice level indicator, and specifically noted the importance of monitoring physical health of patients with SMI. NICE team to explore a composite indicator at three and half, and five and half years in line with the National Screening Programme.

Indicator NM21 (MH009)

**Action:** The committee agreed to keep on the NICE menu at network level, not as a general practice level indicator.

Indicator NM21 (MH010)

**Action:** The committee agreed to keep on the NICE menu at network level, but not as a general practice level indicator, and to align with a nine-month timeframe as per NM21 (MH009).

Indicator NM30 (OST002)

**Action:** The committee agreed to keep on the NICE menu at network level, but not as a general practice level indicator.

Indicator NM31 (OST005)

**Action:** The committee agreed to keep on the NICE menu at network level, but not as a general practice level indicator

Indicator NM111 (PC002)

**Action:** The committee agreed to retire from the NICE menu as it would no longer be considered reflective of current practice.

Indicator NM92 (STIA008)

**Action:** The committee agreed to retire from the NICE menu as it would no longer be considered reflective of current practice.

Indicator NM91 (HYP006)

**Action:** The committee agreed to retire from the NICE menu as NM53 and NM54 are more clinically appropriate indicators.

Indicator NM86 (CHD002)

**Action:** The committee agreed to retire from the NICE menu. NICE team to include a new indicator reflecting QOF indicator CHD009.

Indicator NM93 (STIA003)

**Action:** The committee agreed to retire from the NICE menu. NICE team to include a new indicator reflecting QOF indicator STIA011.

Indicator NM34 (PAD002)

**Action:** The committee agreed to retire from the NICE menu. NICE team to include a new indicator for people aged 80 and over.

**Item 5a and 5b – Indicator development – exploratory work: Dementia, depression and anxiety**

CDG informed the committee that NHS England and GPC England had identified dementia, depression and anxiety as priority areas for indicator development and presented background information to support discussion for the committee.

The committee were asked to discuss and highlight possible aspects for indicator development in line with these new priority areas.

**Depression and anxiety**

* The committee highlighted the importance of NICE quality standards in indicators development but noted that most of those surrounding the topics of mental health tend to be older publications, and that updated quality standards and indicators are more focused on personalised care. It was also noted that the QOF has only a small number of indicators focused mental health.
* The committee highlighted over-treatment with antidepressants as a potential quality improvement area. It was noted that there is a lack of knowledge among practices and patients regarding potential side effects.
* The committee noted that comorbidity in older patients needed consideration due to the large coexistence of depression and anxiety with other conditions related to old age such as osteoarthritis.
* The committee highlighted the importance of identifying the severity of depression.
* The committee highlighted the anxiety disorders quality standard and potential for use in indicator development.
* The committee highlighted the Improving Access to Phycological Therapies (IAPT) programme and potential for their findings in future indicators development.

**Dementia**

* The committee discussed how care of people with dementia is constantly improving but that there are still significant improvements that can be made, particularly regarding the importance of a person-centered approach to treating the condition. It was noted that the patients needed to be more involved in the conversation surrounding their own care, particularly in the early stages of the disease.
* The committee highlighted focusing on carers and families of patients with dementia in future indicators, particularly regarding the role of carer support agencies and care homes and the resource impact on said services.
* The committee noted the importance of medication reviews, particularly psychotherapeutic medication
* The committee discussed the importance of appropriate lifestyle changes in reducing symptoms of dementia.
* The committee highlighted the importance of staff training.

**Action:** NICE team noted all considerations by the committee and will arrange working groups to discuss further development. The committee will be kept appraised of all updates.

**Item 6 – Review of decisions**

CDG gave a summary of the day’s business including all recorded decisions and actions.

**Item 7 – AOB**

AB thanked the committee and staff from NICE and NEQOS for their input over the two-day meeting and in preparation for the committee meeting.

**Close of meeting**