# National Institute for Health and Care Excellence

### Indicator Advisory Committee meeting minutes

**Date:** 6 December 2022

**Location:** Virtual via Zoom

**Attendees:**

**Indicator Advisory Committee members:**

Ronny Cheung (RC) [chair], Andrew Black (AB) [vice-chair], Adrian Barker (ABa), Chloe Evans (CE), Linn Phipps (LP), Liz Cross (LCr), Victoria Welsh (VW), Waqas Tahir (WT), Mary Weatherstone (MW), Elena Garralda (EG), Rachel Brown (RB), Kate Francis (KF), Ben Anderson (BA), Paula Parvulescu (PP), Martin Vernon (MV), Tessa Lewis (TL), Chris Gale (CG), Raju Reddy (RR), Chris Wilkinson (CW)

**NICE attendees:**

Mark Minchin (MM), Nicola Greenway (NG), Rachel Gick (RG), Rick Keen (RK) [minutes], Rosalee Mason (RM) [host]

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

Andrea Brown (ABr), Kate Thurland (KT), Jackie Gray (JG), Tony Roberts (TR), Elizabeth Blanchard (EB), Ellie Mitchell (EM)

**NHS Digital:**

Laura Corbett (LC)

**Topic expert:**

Smeeta Sinha (SSi) – National Clinical Director, Renal Services

**NICE observers:**

Jessica Bailey, Melanie Carr, Charlotte Fairclough

**Apologies:**

Craig Grime, Mieke van Hemelrijck, Dominic Horne, Michael Bainbridge

**Quoracy:** the meeting was quorate.

**Outline of the meeting**

RC welcomed the attendees and the indicator advisory committee (IAC) members introduced themselves.

**NICE advisory body declarations of interest**

RC asked committee members to declare all new interests, that is those not already included in the register of declared interests NICE has on file (and circulated in today’s papers) and all interests related to items under discussion during the meeting. No new interests were declared.

**Item 1 - Review of minutes and actions from November 2022 meeting**

MM informed the committee that all actions from the last committee meeting in November 2022 had been progressed or were included in today’s agenda.

The November 2022 minutes were approved by the committee as an accurate record.

**Item 2 – Immunosuppressed register (IND2022-128)**

KT updated the committee noting that the NCCID had been asked to explore the potential construction of a register indicator for people who are immunosuppressed and explore the number of patients eligible at practice level. The request to develop a register in this area originated following a request from NHS England to NICE.

KT presented two types of immunodeficiency disorders, which result in a full or partial impairment of the immune system: primary immunodeficiencies (PIDs) and secondary immunodeficiencies (SIDs). It was highlighted that SIDs are more common than PIDs and can often be resolved by treating the primary condition. It was noted that NICE guidance on immunosuppression is not currently brought together under a single condition or disease, or as a population group.

KT highlighted the development and refinement process for the definitions of immunosuppressed groups since August 2017 and listed known immunosuppressive conditions and treatments. The committee heard that via UK Health Security Agency (UKHSA) data, 0.9 percent of the population of England are estimated to be immunosuppressed.

KT presented two potential options for the immunosuppression register type noting that any register must include primary immunodeficiencies:

* a ‘fluctuating’ register, including conditions which lead to temporary immunosuppression or conditions that lead to immunosuppression if not effectively managed, or
* a ‘persisting’ register, if a group of conditions and treatments can be identified, in addition to the primary immunodeficiencies, that represent a life-long high risk of immunosuppression.

It was noted that in both cases, ‘increased vulnerability conditions’ might be relevant for inclusion. Various challenges were identified surrounding the fluctuating nature of immunosuppression, the likely need for an electronic tool which uses existing information within the electronic primary health care record to identify those who are likely to be, or be at risk of, immunosuppression, under and over-identification and register maintenance.

The committee were asked to consider the following:

* The purpose of an immunosuppression register.
* Is a ‘fluctuating’ or a ‘persisting’ register most appropriate?
* If a ‘fluctuating’ register is more appropriate, how broad or narrow should the register be?
* Should ‘increased vulnerability conditions’ such as asplenia and morbid obesity, which are not generally classed as immunosuppressive but make the individual more vulnerable to infection, be included?
* As such a register seems feasible at GP level, would there be any benefit to having this register at PCN level?
* Should an age cut-off be applied to the register?
* If a decision is made to proceed, further issues and potential adverse impacts, including any impact on health inequalities, should be explored thoroughly through piloting.

The committee suggested that further clarity would be needed as to the purpose and use of the register as this would make it easier to identify who needs to be included in it. Consideration was given as to what benefits the register would bring such as increased speed and efficiency in identifying immunosuppressed groups. The NICE team suggested that it may be useful to contact colleagues at the Joint Committee on Vaccination and Immunisation (JCVI) to help provide clarity on how this register may add value, and to provide a steer on its development into 2023.

Members expressed support for a fluctuating register as it ensures that all the right groups are being captured. Different guidance is available for those considered at 'increased vulnerability' (but not immunosuppressed), and these groups are often on existing primary care registers, therefore it was agreed these groups should not be included in any definition. It was highlighted that there would be no need for it at PCN level as they would utilise the practice level registers. It was noted that the COVID-19 pandemic highlights the need for an established register, with a nationally agreed specification but that it would still create a significant resource impact at practice level to maintain them. It was agreed that there should be no age cut off until the purpose of the register is established.

The committee heard that there would difficultly in applying a blanket rule for all secondary immunodeficiencies including 1-year post-cancer treatment patients. It was suggested that specification would need to be given that just because a person is not on a specific register, they may still be at risk in a broader category.

It was noted that people may or may not wish to know that they are on the register. Concerns were raised over potential litigation and the need for clinical validation in that immunosuppressed people may be missed from the register. Concerns were raised that there may be circumstances where patients request to be included on the register if involvement granted priority access to vaccines as was the case during COVID-19.

**ACTION: NICE team to start development of a practice level indicator (IND2022-128) on a fluctuating immunosuppressed register that does not include those at increase vulnerability and has no age cut off. Further clarity to be sought on the purpose of the register via consultation with the JCVI with a suggestion to link with the NICE sepsis guideline group. This indicator will be brought back before the committee in June 2023.**

**Item 3 – Impact and Investment Fund indicators (IND2022-129 + IND2022-132)**

RG presented to the committee two Impact and Investment Fund (IIF) indicators on annual health checks and action plans for people with learning disabilities, and inhaler prescription frequency for people with asthma. It was heard that while both indicators are currently on the IIF 2022/23, NHS England wanted to explore if the two indicators were suitable for the 2024/25 QOF. It was noted that no consultation or testing had been undertaken on these indicators.

**IND2022-129**

*Percentage of patients on the QOF Learning Disability register aged 14 or over, who received an annual Learning Disability Health Check and have a completed Health Action Plan.*

RG highlighted that people with a learning disability often have poorer physical and mental health and that they are four times more likely to die of preventable illness in the general population. It was also noted that an annual health check can help to improve the health of this population by identifying health concerns at an early stage. It was highlighted that the health action plan is an integral part of this check.

The committee were asked to consider the following:

* Should the indicator progress to the NICE menu as suitable for QOF?
* Alternatively, is further testing or consultation required?
* Historically the learning disability register may have underrepresented the population. Has the completeness of the register improved since 2019?
* Are there any barriers to implementation of this indicator to be aware of as current IIF achievement is low (24.2%)?

The committee noted that while there was a preference for the indicator to operate at practice level, the denominator numbers may be too small to be suitable for the QOF in some practices and therefore must operate at PCN level. It was agreed that this would be clarified during the consultation and testing phase. Concerns were raised about historically poor coding, particularly for people moving in and out of an area. The need for specialised training to carry out the review was also noted. It was highlighted that areas in which a learning disabilities nurse conducted the review correlated with higher levels of access. It was highlighted that the appointments need to be lengthy and that patients sometimes cancel them at the last minute; home visits may be needed.

The committee queried the rationale of moving this indicator into the QOF given that, as an existing IIF indicator, it may mitigate small number at practice level by focusing on supporting PCNs. It was however suggested that the QOF has a higher profile than the IIF; including this indicator in the QOF would improve achievement and patient outcomes.

The committee noted, further to earlier discussion of its value, the indicator’s importance in relation to the increasing number of premature births reflecting improvement in care; the increase may lead to a greater number of people with learning disabilities and who consequently need the health check. It was also highlighted that a greater proportion of children with learning disabilities are surviving later into life. The committee noted existing health inequalities in more deprived areas and complexities around coding where people may not reside at home, and that any indicator must recognise the challenges practices face to reach this patient group.

**ACTION: NICE team to progress further testing and consultation on IND2022-129 to review denominator numbers and potential barriers to establish feasibility.**

**IND2022-132**

*Percentage of patients on the QOF Asthma Register who were prescribed five or more inhaled corticosteroid (ICS, inclusive of ICS/LABA) inhalers over the previous 12 months.*

RG highlighted that inhaled corticosteroids (ICS) are the most effective and first choice preventer drug for adults and older children with asthma. Regular use of ICS’s can improve asthma symptoms, reduce reliance on short acting beta agonists (SABA) and prevent exacerbations and mortality. It was also noted that most inhaled corticosteroids can be delivered via dry powder inhalers and that these have a significantly lower carbon footprint than metered dose inhalers.

The committee were asked to consider the following:

* Does the indicator have general validity as an indicator suitable for inclusion in the QOF?
* Once we do have the business rules would consultation or testing would still add value?
* NICE guideline on asthma is currently being updated and is expected to be published in November 2023. NICE guidance does not state the minimum number of inhalers that indicates good quality care. Is this a good measure of quality care?
* This indicator is not yet suitable for progression to the NICE menu: Business rules have not yet been constructed for the new IIF version. Unclear how inhalers will be counted. If counting inhalers is not possible, is counting the number of prescriptions still useful?

The committee questioned the evidence base for this indicator and noted that focusing on prescription counts may not be a measure of quality of care. It was noted that prescribing regimes for single maintenance and reliever therapy (SMART) and maintenance and reliever therapy (MART) may present measurability issues. The committee also felt that changing therapy regimens should be discussed at reviews. The indicator was not supported as being potentially suitable for use in the QOF.

**ACTION: NICE team to discontinue any further work on IND2022-132 and consult with NHS England on the need to identify other indicators on asthma care.**

**Item 7 – Vaccinations and Immunisations (PJ-02)**

KT presented to the committee three indicators on childhood immunisation that were added to QOF in April 2021:

* **VI001**: *The percentage of babies who reached 8 months old who have received at least 3 doses of a diphtheria, tetanus and pertussis containing vaccine before the age of 8 months (payment threshold 90-95 percent).*
* **VI002**: *The percentage of children who reached 18 months old who have received at least 1 dose of MMR between the ages of 12 and 18 months (payment threshold 90-95 percent).*
* **VI003**: *The percentage of children who reached 5 years old who have received a reinforcing dose of DTaP/IPV and at least 2 doses of MMR between the ages of 1 and 5 years (payment threshold 87-95 percent).*

KT noted that stakeholders had raised concerns that the indicators are difficult to achieve and may widen inequalities. It was highlighted that based on the equivalent latest official indicators for 2020-21 (Public Health Outcomes Framework), all childhood vaccination levels are below the 95 percent target for herd immunity and with a recent decreasing trend.

KT highlighted that an analysis of these three indicators was conducted via the NCCID following concerns that were raised at the June 2022 IAC meeting. KT presented the methodology for this analysis and highlighted that 9.2 percent of practices are currently achieving maximum points for all three indicators, with 41.8 percent of practices achieving at least some QOF points for all three indicators. It was heard that 24.2 percent of practices achieved zero points for all three QOF indicators. The analysis fielded the following conclusions:

QOF achievement: childhood immunisation

* Practices appear to have found the new QOF immunisation indicators challenging.
* QOF achievement varied geographically.
* There were inequalities relating to deprivation in QOF achievement.

Likely implications for vaccine coverage as reported officially through the Public Health Outcomes Framework since April 2021

* No suggestions of an improvement in vaccine coverage during 2021-22 and into the first quarter of 2022-23, compared with 2020-21.
* Vaccine coverage appears particularly low in London and around the Birmingham and Black Country areas.
* Vaccine coverage is lower in areas of higher deprivation, and inequalities appear to have increased in 2021-22.

Impact of incentivisation

* The activity data examined does not provide any evidence of changes in vaccine delivery.

The committee were asked to note the conclusions of this analysis and consider points to be fed back to NHS England (NHSE) and the British Medical Association (BMA) as the contract negotiators.

The committee noted concerns over the small numbers affecting the indicator’s attainment levels where there is parent and carer choice over not vaccinating young children. It was highlighted that attainment numbers may be affected by people coming from abroad given that they could have received vaccinations from different programmes. The committee heard that NHS Digital have drafted coding to capture people who have already missed their target or do not have the time to vaccinate. It was highlighted that extra PCAs have been drafted in to capture these scenarios.

Members noted that poor achievement becomes especially prominent in deprived areas and that these practices receive fewer financial incentives. In addition, there are practices in less deprived areas who are starting to slip on meeting vaccination targets. It was suggested that there could be a staged target, adjusting for levels of deprivation. Concerns were raised that there is often mistrust and a lack of understanding of the issues surrounding vaccinations leading to no uptake among people despite their being eligible. It was highlighted that you can 'fail' indicator VI001 by missing the deadlines but still achieve VI003 (as there are no restrictions placed on the initial vaccination timings within the definition for VI003). It is the case that complete failure to give the VI001 vaccinations (to any timescale) means you cannot then achieve VI003 as it requires a booster for these vaccines.

**ACTION: NICE team to share NCCID’s analysis with NHSE and the BMA along with the feedback from the committee. NICE team to share the minutes of this meeting with both organisations.**

**Item 4 – chronic kidney disease: SGLT2 inhibitors (IND2022-135)**

SSi noted her declarations of interest and presented to the committee on the clinical importance of SGLT2 inhibitors for people with chronic kidney disease (CKD). It was noted that CKD stage 3-5 prevalence ranges from 3 to 9 percent, prevalence increases with age with continued growth projected, and that there is variability in the rates of detection nationally with blood tests faring better than urine testing. It was noted that approximately 1.5 billion pounds is spent on CKD annually within the NHS, with a very small amount dedicated to finding patients in primary care with CKD and getting them onto the correct medications.

SSi highlighted an historic QOF indicator (CKD004) on patients on the CKD register receiving a urine ACR test in the preceding 12 months. It was noted that once the indicator was discontinued in 2015 there was a significant falloff in recorded urine ACR testing indicating a falloff in early diagnosis. The importance of ACR testing was highlighted particularly in detecting the early signs of diabetic kidney disease before significant nephron loss occurs. SSi highlighted several clinical trials that had looked at the use of SGLT2i in people with CKD and presented some key results from the DAPA-CKD trial. The study showed clear data of up to 50 percent declines in eGFR, ESRD, and renal or cardiovascular death in CKD patients prescribed Dapagliflozin.

SSi and ABr proposed to the committee a new indicator on the use of SGLT2 inhibitors for people with chronic kidney disease (CKD) already being treated with ACEi/ARB:

*The percentage of patients on the CKD register and either an ACR of 22.6mg/mmol or more or with type 2 diabetes and a urine ACR more than 30mg/mmol and currently treated with an ACE-I or ARB, who are currently treated with an SGLT2 inhibitor.*

ABr highlighted that this indicator would aim to improve the quality of care and reduce the risk of adverse outcomes for patients with CKD.

The committee were asked to consider the following:

* Ability to identify target population / interim measures required.
* Can we assume most / all patients being treated with ACE/ARBs are on the max tolerated dose?
* Will this widen health inequalities (ARB/ACE prescribing rates, CKD prevalence is underestimate)?
* Should the CKD register definition be updated in terms of categories?
* Eligible numbers of patients presented may not be robust enough.
* Currently only 1 SGLT2i for CKD.

SSi noted that there should be no issue with moving in and out of criteria as patients were not taken off the drug during clinical trials until n-stage kidney disease. It was highlighted that there is a potential for confusion between differing thresholds. It was suggested that leaving out ACRs from the indicator wording might solve this problem, as would having a single ACR reading at 30mg/mmol which is the highest threshold out of all clinical studies. Members noted that removing ACRs from the indicator would have little effect as the patient will already be on the CKD register. It was highlighted that keeping ACR within the statement would align it to NICE guidelines and technology appraisals. It was highlighted that there is a new NICE technology appraisal in development on the use of empagliflozin for people with CKD. Committee were interested as to when this appraisal would publish and if there were any plans to update the NICE guideline on CKD.

The committee noted that use of maximum tolerated doses of ACE/ARBi inhibitors is not currently widely achieved. It was highlighted that there is a potential for side effects that may require a secondary indicator to promote patient information and monitoring. SSi noted a meta-analysis via the Lancet on SGLT2i inhibitor use that demonstrated patient outcomes. It was heard that the studies were terminated early due to the benefit to the patients rather than because of the side effects. SSi suggested that SGLT2 inhibitors are well tolerated when compared with standard treatment of ACE inhibitors and ACRs. Patients at high risk of diabetic ketoacidosis would not be prescribed SGLT2 inhibitors. Concerns were raised that it would be inappropriate to prioritise this indicator within CKD given the numerous issues already existent such as blood pressure management, suboptimal prescribing of ACE/ARBs and low urine ACR testing. However, it was noted that the NICE indicator menu already covers a range of interventions for people with CKD and developing an indicator for SGLT2s would further expand the range.

**ACTION: NICE team to consider development of IND2022-135 pending further investigation. Smeeta Sinha to provide ongoing consultation. NICE team to confirm when the NICE guidance on CKD will be updated, and when the technology appraisal on empagliflozin will be published.**

**Item 5 - Blood pressure: frailty and age (PJ-03)**

EM and NG presented to the committee an analysis of current QOF blood pressure indicators relating to frailty and age. It was highlighted that at the June 2022 IAC meeting, committee members noted that some indicators that use moderate frailty as a diagnostic code to identify populations could be risking under-treatment due to the coded classification having poor diagnostic accuracy, and some patients with moderate frailty being excluded unnecessarily. The committee heard that NHSE asked NICE whether indicator DM019 should stratify patients by age, in line with NICE guidance, and if existing blood pressure indicators in other disease areas also stratify by frailty (in addition to age).

EM presented the following summary of NCCID’s analysis:

* Unknown level of batch coding and levels of clinical validation following an eFI.
* Inconsistencies in frailty identification (Wide variation in the level of frailty assessments carried out and moderate and severe coding).
* Disparities in modelled estimates of frailty and existing frailty codes.

It was noted that these factors contribute to reduced quality of frailty coding which may have implications on patient care and QOF achievement:

* Considering these points, the patient populations at risk of over- or under-treatment should be considered
* The data presented has demonstrated that there are patient populations at potential risk of over- or under-treatment in current QOF/NICE indicator.

The committee were asked to consider the following:

* Should the existing QOF diabetes indicators continue to be stratified by moderate and severe frailty?
* Should blood pressure monitoring indicators also include stratification by frailty?
* Where does stratification add most clinical value?
* Are there any specific proposals to explore further?
* Should there be a consistency for stratification for blood pressure monitoring (i.e. should the diabetes indicator NM218 (an update to NM159) continue to be stratified by frailty, or should this instead (or also) be stratified by age?)

The committee agreed that indicator NM218 should be amended in line with NICE guidelines and include an age-cut off.

Members highlighted the importance of identifying variation across primary care for coding of frailty. It was noted that there may be issues where there is variation within the indicators.

The committee suggested that blood pressure indicators should not be stratified by frailty especially if the electronic frailty index (EFI) is used alone. It was noted that it includes conditions such as sleep disturbance, incontinence, hearing impairment and hypertension, conditions of which become more prevalent with age. It was highlighted that there is a potential to confuse old age with clinically validated frailty. It was noted that via such conditions the absolute risk reduction for blood pressure management may be higher as you have a baseline risk that is higher than the rest of the population. The committee heard that we do not know what the impact of frailty is on the efficacy of blood pressure treatment. It was highlighted that there are number of complexities in blood monitoring for people who are frail especially given that blood pressure drops as a person approaches the end of life. It was suggested that without randomised control trials in this field then you will not have an effective evidence base in support of stratifying frailty indicators.

Members noted that the purpose of frailty as a marker was to mitigate potential risks associated with over-treatment. It was highlighted that the EFI was only designed to be a segmentation tool and a not a diagnostic one. It was noted that personalised care is very important, and that people should not be removed from indicators based on frailty recording alone. It was highlighted that all decisions must come down to a shared decision-making process between the clinician and the patient without risking over-treatment. It was suggested that great emphasis should be placed on interventions and stopping people becoming frail in the first instance. It was suggested that the business rules surrounding personalised care adjustments (PCAs) could be utilised for frailty. It was noted that this would rely on there being a conversation between clinician and patient.

**ACTION: NICE team to conduct further analysis as to what can be achieved via PCAs in terms of stratifying frailty before bringing the issue back before the committee. Indicator NM218 to be amended in line with NICE guidance including an age cut off.**

**Item 6 – Health inequalities and complex needs (PJ-01)**

EB presented to the committee a proposal to enhance the indicator development process to place greater emphasis on identifying health inequalities and complex needs.

In the June IAC committee members had raised concerns that indicators can perpetuate or exacerbate existing health inequalities and concerns that the implementation of indicators and resulting performance reporting does not allow adjustment for practices with greater proportions of hard-to-reach patients. Additionally in July 2022, NHS England expressed interest in the potential for existing indicators to better account for patients with complex needs.

Following on from these concerns and the interest from NHS England, EB presented to the committee proposals of options to address the following three points:

• Exploration of options for the development and implementation of indicators that could help mitigate the risks of perpetuating or exacerbating health inequality.

• Exploration of options for the development and implementation of indicators that could help mitigate the risks of disadvantaging practices/providers with a higher proportion of patients who may be harder to reach.

• Exploration of the potential to update existing NICE/QOF indicators to account for complex needs.

As part of this EB also discussed her analysis exploring the types of inequality that might be perpetuated or exacerbated by the NICE Indicator development process which primarily focused on indicators relating to QOF.

The analysis fielded the following conclusions:

Findings from reviews and data analysis: Perpetuating or exacerbating health inequality

* The NICE indicator development process and indicator construction may impact health inequalities. Examples include:
	+ The current NICE indicator development process may not always identify how health inequalities may be perpetuated or exacerbated by indicators once they are incorporated into a pay-for-performance scheme such as QOF.
	+ Prioritising areas for indicator development may exacerbate inequalities by choosing to focus on and/or incentivise the care of specific conditions to the exclusion of others.
	+ Thresholds associated with QOF indicators may result in hard-to-reach patients being missed from receiving interventions.
	+ Indicators are not optimising opportunities for case-finding, resulting in inequalities for patients with missed diagnosis.
	+ Certain patient groups may currently not be receiving appropriate interventions/targets as indicators are out of line with NICE guidance.
	+ Financial incentivisation associated with certain indicators may disincentivise work towards non-incentivised indicators disadvantaging some patient groups.
	+ Lack of resources may impact a practice’s ability to achieve QOF indicators. A negative cycle forms with practices not meeting targets due to lack of resources and therefore not being able to invest in improvements to quality of care.

EB presented options identified in the report to mitigate these risks for the committee’s consideration.

Findings from reviews and data analysis: Mitigating the risks of disadvantaging practices with a higher proportion of patients who might be harder to reach

* Defining ‘hard to reach’ is complex.
* Coding of factors which may suggest a patient is hard to reach is not always comprehensive.
* Within the eight indicators analysed, overall PCA reporting and QOF achievement is similar in patients with learning disabilities and severe mental health conditions compared to the sample population average. However, there are a couple of exceptions.
* The proportion of PCAs applied to indicate that a patient has had two invitations but has not responded is higher in patients with severe mental health conditions than the sample population average.
* Although practices in deprived areas appear to have maintained their QOF income it has been suggested that this may be because of considerable increases in workload compared to less deprived practices.

EB presented options identified in the report for mitigating the risks of disadvantaging practices with a higher proportion of patients who might be harder to reach.

Findings from reviews and data analysis: Potential to update existing indicators to account for complex needs

* There is no single definition for complex needs.
* Current coding of complex needs is poor.
* Within the eight indicators analysed, overall PCA reporting and QOF achievement is similar in patients with learning disabilities and severe mental health conditions compared to the sample population average. However, there are a couple of exceptions.
* The proportion of PCAs applied to indicate that a patient has had two invitations but has not responded is higher in patients with severe mental health conditions than the sample population average.
* The proportion of PCAs applied to indicate that the care or treatment is unsuitable is higher in people with learning disabilities than in the sample population average.
* Currently, only a few indicators within QOF directly account for complex needs, for example, some of the indicators in the diabetes mellitus group. However, in addition to frailty, NICE guidance details several other areas where diabetes management should consider complex needs.

EB presented options identified in the report to consider when updating existing indicators to better account for complex needs.

The committee were asked to consider the options that had been presented to them as recommendations to address each of the three tasks, whether they wanted to explore any of the options further, opinions on each of the suggestions and whether they had any suggestions of further strategies to address each of the points.

The committee noted that the term ‘hard to reach’ does not align with current terminology, it was suggested that alternative language be explored and used.

The committee referenced NHSE’s Core20plus5 programme for tackling health inequalities and suggested alignment to this work. It was queried as to how you can use improvement measurements to benefit said deprived populations. It was noted that payments are already made based on weighted population which could be drawn on to consider the issues of deprived populations. However, it should be noted that a practice’s QOF payment is based on the number of points they achieve, their list size and an adjustment for the prevalence of disease, not directly deprivation. It was highlighted that practices engaging with populations that seek to benefit the most from interventions can often cost more but deliver a greater return on investment. It was suggested that this would need to be consider for future guidelines and indicator development. Additionally, concerns were raised around data quality on deprivation in small areas and how to ensure any extra payments reflect and lead to improvements for deprived groups.

Members queried as to whether this could be better achieved at PCN level via the IIF given the struggle smaller practices have to reach deprived populations. It was heard in one area they can identify, and segment populations based on service use through the “Connected Care” system, and there is ongoing work around stratifying by the core 20%.

The committee noted the importance of ensuring that this work is embedded within the principles of indicator development, and that any potential for the widening of health inequalities is brought to the forefront of the discussion at the IAC. Committee members highlighted that they thought that the barrier to implementation is already addressed in the indicator piloting, consultation, and equality impact assessment processes. However, the NICE team acknowledged that there is always room for improvement in said processes and committee members agreed that the pilot and consultation phases are important stages for the consideration of health inequalities

**ACTION: NICE team to review the indicator development process to see if improvements can be made in identifying and addressing health inequalities. Suggestion to change the terminology from ‘hard to reach’ to ‘underserved’ or ‘hardly reached’. PJ-01 to be brought back to a future IAC meeting.**

**Item 8 - Review of decisions**

MM confirmed details of the business and all recorded decisions and actions discussed had been noted.

**AOB**

None.

**Close of meeting**