Indicator Advisory Committee Meeting

Minutes of the meeting held on Monday 12th March

NICE Office, Manchester

Attendees	**Committee Members:** Daniel Keenan (DK) [chair], Andrew Anderson (AA), Nigel Beasley (NB), Andrew Black (AB) [vice chair], Rachel Brown (RB), Ronny Cheung (RC), Kate Francis (KF), Richard Garlick (RG), Simon Hairsnape (SH), Jo Jerrome (JJ), Dominic Horne (DH), Tessa Lewis (TL), Linn Phipps (LP), Allison Streetly (AS) and Mary Weatherstone (MW) **NICE Attendees:** Brian Bennett (BB), Craig Grime (CDG), Rick Keen (RK) and Mark Minchin (MM) **NICE Collaborating Centre for Indicator Development (NCCID):** Andrea Brown (ABr), Fredi Garbe (FG) and Paula Whitty (PW) **NICE observers:** Olivia Crane, Rachel Gick and Shaun Rowark
Apologies	Chris Gale, Robert Walton, Tony Kendrick, Elena Garralda

Agenda item	Discussions
Item 1 - Outline of meeting	DK welcomed all attendees and went through the planned business of the day. Apologies were noted.
Item 2 - NICE advisory body declarations of interest	RG told the committee that he has now retired as a full time salaried GP but is still completing locum work.
Item 3 - Review of minutes and actions of December 2017 committee	BB told the committee that the actions from the December 2017 meeting had been progressed as stated in list of actions. He drew the committee's attention to the timing of the consultation this year, advising that this will be held following the announcement of the new GP contract for 2018/19. PW made a point of clarification in relation to actions 8-11 12/17. The data from the revised prospective NCAP audit is expected to be ready for analysis from June 2019 rather than 18 as stated
Item 4 - NICE Indicator programme update and the new NICE declaration of interest policy for committee members	<u>New NICE declarations of interest policy for committee members</u> MM provided the committee with an overview of the new NICE policy on declaring and managing interests for advisory committees. He advised that the new policy will come into effect on 1st April. Committee members will be requested to submit their annual declaration of interest in the new format. A register of all committee member's interests will be made available prior to all committee meetings, for all members of the committee. These will also be kept up to date on the NICE website. Committee members have received the new policy and will be sent further details in the near future. <u>QOF review</u> MM advised the committee that the national review of the QOF is still ongoing with no date set for publication of the outcome. The NICE team will advise the committee of any implications on the programme when an announcement has been made.

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Item 5 – Piloting of GP indicators	ABr gave a progress report on recruitment of practices for the national piloting of general practice indicators. The team have gathered deprivation and practice size information for all practices in England. They then split them into 9 different groups, across 3 levels of deprivation and small, medium and large practice sizes. From this stratification process, 249 practices were contacted by email inviting them to express an interest in taking part in piloting. An excellent response was received and ABr reported that of the original 250, 65 requested further information. Out of that 65, 39 have so far agreed to be involved. This includes 2 practices that are soon to become part of larger 'super practices' with up to 10 additional practices. When reviewed against the different strata, there is a good spread across practice size, deprivation levels and geographical areas. The key clinical IT system supplier's providers are also covered. The committee were invited to ask any questions. AB asked what the total patient numbers would be with a sample of 30 practices and whether including 1 or 2 super practices could skew the findings. AS suggested that if the reports are by practice rather than as a single cohort, then this wouldn't cause an issue. DH recommended that we include the super practices as these reflect the changing service models that are emerging. TL encouraged that as many of the practices that have stated an interest should be included as possible, as there are often some drop outs and it would therefore be good to retain as much interest as possible. TL asked whether the pilot should include practices from the devolved administrations (DAs). PW advised that she had been in contact with the previous contractor and was advised that it had proved difficult to extract data from practices in the DAs. PW was keen to seek a way to involve the devolved administrations however and suggested that they could be involved in the qualitative aspects of the development process. MM asked whether the DAs were carrying out the same transition to SNOMED on the clinical information systems. DK suggested that some further investigation is carried out about any feasibility issues with involving the DAs in the piloting. **Action – NICE to investigate feasibility of involving the DAs in the piloting process** LP asked whether during the qualitative process it would be possible to broaden the range of people involved in providing feedback, to include commissioners and other similar roles. ABr confirmed that the intention is to widen involvement from the practices involved in the focus groups.
Item 6 – Multimorbidity and frailty	ABr went through the work they have done since the December meeting. The key actions were : - To explore 2 different multimorbidity registers looking at proportion of the practice population that would be in each - Review options for the inclusion of non-QOF conditions

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	- Review the initial data concerning the frailty register - Refine the proposed indicators relating to medication review and falls ABr presented analysis of the frailty registers. There is high variation in terms of the proportion of patients recorded as having a frailty assessment and. AB suggested that the variation is as you would expect for a new register and that it will likely settle down after 2-3 years. The committee noted that the data suggests that the proportion of people being recorded as moderate to severely frail seems relatively consistent. ABr then went onto describe the work done looking at what non-QOF conditions could be included in the definitions. A set of potential conditions was presented. This list was developed through a 2 stage approach. NCCID clinicians carried out an initial screen of all UK-relevant chronic diseases and conditions. These were then ranked high to low using age-standardised disability adjusted life years (DALYs). This list of conditions was reviewed and amended by NCCID clinicians The committee reviewed the list. There were some suggestions that it may be easier to group conditions, rather than have single conditions e.g. neurological conditions. Some committee members flagged a few of the suggestions as being acute conditions and that they didn't seem to fit. RC asked whether a more formal process should be used to agree the conditions included in the basket of non-QOF condition, such as a Delphi consensus approach. Further discussion was had about whether there should be a single clinical code created such as 'non-QOF chronic condition' which clinicians could use, with a list of suggested conditions alongside this. NB flagged a journal article that was published in the Lancet (Barnett et al. 2012) which could be of use. MM suggested that advice could also be sought from the chair of the Multimorbidity guidelines group, who has also been a co-author on several relevant publications. **Action - The committee asked that these options were considered further and proposals fed back to the committee for what conditions could be included in the basket of non-QOF conditions and some suggestions about the best way to reach an agreed list that would be auditable.** ABr then went through the data analysis that had been carried out on a cohort of practice populations in the North East. Data had been obtained from 98 GP practices covering 641,502 patients aged 18 years and over. The team had used the data to model a number of scenarios based on the two draft multimorbidity register definitions (a & b), looking at what proportion of the population is included in each scenario. It was agreed that multimorbidity definition option a) was preferred over option b) as in option b) the potential under-coding of some of the 'complexity factors' would result in the figures being underestimated. The committee had a detailed discussion about the different potential scenarios within option a), one of the key questions being whether the register should focus on those with 2+ QOF conditions, which would include a larger proportion of the population (15.2%) or the other end of the spectrum, focusing on those with 4+ conditions, which would be a more targeted

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	register with 3.6% of the practice population. The committee also agreed the inclusion of non-QOF conditions (once refined) and the inclusion of a further characteristic of the presence at least one symptom complex or impairment, for further exploration of this register option. It was agreed that data for option (a) should be explored further, looking at both 2 or more and 4 or more chronic conditions (without further stratification) and having refined the non-QOF condition list. It was also agreed that input from the chair of the NICE guideline on multimorbidity could be useful. **Action – NCCID to discuss the options with Prof Bruce Guthrie, Chair of the NICE Multimorbidity guideline. An updated paper reporting the findings of the further exploration of register option (a) to be shared offline with IAC. Following agreement of this, the options to be drafted up into potential indicators for consultation, for review by the committee** <u>Medication review</u> Proposed indicator - The percentage of patients with frailty 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 taken place as a shared discussion ABr explained that an important feature of this indicator will be ensuring that it is not a tick box indicator and the important role the guidance will have to ensure that the review is meaningful. ABr asked the committee to review a suggestion that the review should include the comprehensive geriatric assessment (CGA). AB suggested that they would need to know the details about what the CGA would include. This point was supported by other members of the committee. ABr explained that it was referenced in a recent BMJ article, where a secondary care geriatric assessment had been used in primary care. Committee members were unsure about this inclusion, suggesting that it may be too structured. DK summed up discussion, with the committee agreeing to progress the indicator without the reference to the CGA in the associated guidance. **Action – following agreement of the register definitions as earlier, progress the indicator for consultation and testing without the reference to the CGA** <u>Falls prevention</u> Proposed indicator - Indicator a) to be revised to: a) The percentage of patients (aged 65 years and over) with moderate or severe frailty who have: i. Been asked whether they have had a fall, about the total number of falls and about the type of falls, in the latest 12 months,

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	and ii. Had a primary care falls risk assessment in the last 12 months, and if at risk, have been provided with advice and guidance with regard to falls prevention (in the last 12 months). TL asked about people who have had a falls risk assessment, have been referred to a falls prevention services but still fall. Would it be possible to exclude them? AB suggested that clinicians could use their own discretion to exclude patients from the indicators where the intervention is not appropriate. Committee members asked for clarification of what is included in a primary care falls assessment and how it would differ from the questions referenced in the first part of the indicator? It was felt that the 2 are referring to the same process. It was therefore agreed to combine the 2 concepts. **Action – following agreement of the register definitions as earlier, the following indicator to be taken forward for piloting and consultation:** a) 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 latest 12 months and if at risk, have been provided with advice and guidance with regard to falls prevention (in the last 12 months).
Item 7 - Alcohol	FG introduced this topic and provided an overview of the work done to date. The team had reviewed all the previous indicator work on alcohol and have suggested areas that could be revisited and also some new areas for potential indicator development. <u>Prevention</u> FG suggested that the area where the greatest health gain could be achieved would be in prevention of hazardous or harmful alcohol use. However, a lot of guidance in this area relates to access to alcohol, with local authorities having responsibility for that. The question was asked whether this area is beyond the remit of the committee. AB noted that NICE does have guidance that covers local authorities and therefore the committee could develop indicators in this area. SH suggested that the remit of the indicators developed by the committee needs to reflect the changes to the health and social care system. SH noted that there is an increasing emphasis on larger system wide organisations like sustainability and transformation partnerships (STPs). It was suggested that if the committee covers public health issues it would be illogical to not include local authorities. AB agreed and suggested that NICE confirm the remit of the programme and feedback at the next committee.

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	Action – NICE to check the whether the remit of the committee can include indicators for local authorities. Hypertension The committee were asked to consider revisiting some indicators previously piloted about screening for alcohol misuse and information provision for people with hypertension. The indicators were: *1) The percentage of patients with a new diagnosis of hypertension in the preceding 1st April to 31st March who have been screened for hazardous or harmful alcohol consumption using a validated tool in the three months before or after the date of entry on the hypertension register.* *2) The percentage of patients with a new diagnosis of hypertension in the preceding 1st April to 31st March who screen positive for hazardous or harmful alcohol consumption who have been given personalised feedback on their AUDIT score and a patient information leaflet about their level of alcohol related risk of harm within 3 months of the AUDIT score being recorded* FG suggested the committee reconsider these indicators, but with some adaptions. Audit – C or the FAST tool could be used instead as this is shorter and therefore easier to complete. For those identified as hazardous or harmful drinkers, an indicator on the provision of brief advice could be considered. AS advised the committee that there is currently a CQUIN in place that does both screening and brief advice within secondary care settings. Mirroring this in primary care would be good. DH flagged that there is currently a broad indicator in the QOF about CVD prevention (CVDPPO2) that covers alcohol consumption amongst at risk groups. AB asked whether it is worth developing some condition specific indicators in addition to CVDPP02. TL suggested that alcohol use in people with hypertension is under managed and some specific indicators should be progressed. AB summarised the committee's discussion, confirming agreement to go forward with some amended indicators for people with hypertension that use one of the shorter screening tools. **Action – Progress indicators focused on alcohol screening and brief advice in people newly diagnosed with hypertension using one of the shorter screening tools.** Patients currently excluded from NHS Health Checks FG asked the committee to consider whether it would be worthwhile progressing indicators looking at alcohol screening and brief advice for people excluded from NHS Health Checks due to them already being diagnosed as having, or at risk of

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	,cardiovascular disease (i.e. people on cardiovascular, diabetes or dementia QOF registers) The committee agreed that this is a good idea, but that a pragmatic approach would be to do a composite indicator (an overarching indicator similar to the smoking indicator) that covers all conditions excluded from NHS Health Checks. The committee then discussed the timeframe for these indicators and whether the screening should take place on an annual basis, at a longer frequency (e.g. every five years) or be a one off. AB suggested that this is something that should be investigated at consultation. TL asked about including people on proton pump inhibitors and whether they could also be included. It was noted that it can be hard to identify a population based on prescribing data. There would be a question about whether this would include people with a one off prescription or those with longer term prescriptions. **Action – Progress indicators on alcohol screening and brief advice in populations not included in NHS Health Checks, with a specific aspect of piloting and consultation to consider the timeframe for screening - whether it is at diagnosis, annually or 5 yearly for example.** <u>Dual diagnosis</u> FG asked the committee to consider whether it would be worthwhile progressing indicators looking at identification and intervention in people with depression, anxiety and those with severe mental illness. Committee members agreed that this is a priority area considering the much higher prevalence of harmful alcohol consumption amongst these groups. RB asked whether these groups could be added to the current overarching indicator on alcohol. MM flagged the issue seen with the smoking indicators where data showed that composite indicators were hiding low achievement amongst people with SMI. It was agreed to take these forward as standalone indicators. There was some discussion about whether these indicators should be focused on primary care or secondary care. The committee agreed that there could be a set of linked indicators covering both settings and that this should be considered following the development of the primary care indicators. **Action – Progress primary care level alcohol indicators on identification and interventions in people with depression, anxiety and also people with SMI. Also look at the potential for system wide indicators in this area.** <u>Follow up and outcomes</u> FG asked the committee to consider whether it would be worthwhile progressing indicators looking at the effectiveness of follow up after identification of harmful alcohol consumption. The committee agreed that it is important to measure the extent services are treating people when people are identified. There was some discussion about whether children and young people should also be picked up. However, it was agreed that education around the risks of alcohol consumption should be addressed in school and primary care clinicians rarely see young people to be able to have the discussions. The committee agreed to progress indicators on post screening care

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	Action – progress indicators on post screening care Early detection of alcohol-related liver disease – potential indicators FG flagged the significant increase in the mortality rate from liver disease in this country. AS added to this, highlighting that we are doing very badly compared to the rest of the world and the situation is getting worse. AB asked whether indicators in this area would rely on access to tests for liver fibrosis. If so, it was suggested that currently these are not widely available. TL also flagged that indicators in this area could include a large number of patients, so access would be an issue. FG advised that there is some work happening nationally to look at implementation issues around NG50 involving the British Liver Trust. The committee agreed to further explore indicators on early detection of alcohol-related liver disease, investigating associated access issues to tests for liver fibrosis and what part of the system these indicator would best sit. **Action – NICE team to further explore what data are available to support indicators on early detection of alcohol-related liver disease, including tests for liver fibrosis.** Secondary care indicators: Opportunistic Identification and Brief Advice (IBA) in line with 'Making Every Contact Count' FG highlighted statistics showing that 75% of people diagnosed with alcohol-related liver disease had contact with hospital services prior to diagnosis. The committee was therefore asked whether it would be worthwhile to progress indicators looking at opportunistic identification and brief advice of harmful or hazardous drinking in secondary care setting. NB suggested that this is standard practice within secondary care services. AA asked what would happen if someone is identified as having harmful / hazardous levels of drinking at a secondary care setting? SH suggested that where it is identified, some basic advice will be given and then people are generally advised to contact their GP if they are concerned. The committee noted that there is a CQUIN in place for secondary care and that it may be worthwhile waiting for the CQUIN to bed in and then review this area again. This suggestion was agreed to by the committee. **Action – Add the area of opportunistic IBA in secondary care to the log for future consideration in 2020, following a review of the secondary care CQUIN scheme.** Secondary care indicators: Specialist alcohol treatment services FG asked the committee whether it would be worthwhile to progress indicators looking at referral into and follow up from specialist alcohol services. There is an opportunity to use the National Drug and Treatment Monitoring System that could

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	inform indicators on treatment and outcomes. The committee agreed that this is an important area, particularly identifying where there is variation in treatment and outcomes. **Action – Progress indicators on treatment and outcomes from specialist alcohol treatment services** As a final action, DK suggested that a visual map based on the pathway in the paper, would be useful in order to summarise the existing indicators identified and the areas agreed to progress for indicator development. **Action – future papers for the committee in this area to include a visual map of the alcohol pathway, including existing indicators and indicators being progressed.**
Item 8 – Managing common infections	TL gave an overview of the antimicrobial prescribing guidelines. There is a set of topics that have been confirmed with more to follow. The guideline development process is shorter than that for other NICE guidelines with a 12 month development time. AB suggested that this is a rolling programme and that there will likely be opportunities to identify areas for indicator development that could be worked up before the completion of the full guideline programme. The committee discussed that these indicators would likely be for improvement rather than financial incentivisation. AA supported the idea of giving GP's support in managing demand for antibiotics. NB flagged that any indicator development process for these indicators will need to consider unintended consequences as there have been cases where people are experiencing acute illness where antibiotics haven't been prescribed. TL asked whether the proposal to develop an indicator based on linking a diagnosis with any antibiotic prescription would be revisited. NICE agreed to review this and discuss feasibility with NHS Digital colleagues. DK asked TL whether there are any of the new guidelines that could be considered for indicator development in the first instance. TL suggested UTI could be a good starting point, with the committee agreeing that having a checklist for managing some conditions like UTI would be useful. The committee asked the NICE team to bring back proposals for antimicrobial prescribing to the June committee meeting. **Action – NICE team to submit a briefing paper on potential antimicrobial prescribing indicators to the June committee.**

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Item 9 – Review of the days business	DK thanked the committee and staff from NEQOS and NICE for the work today and in preparation for the committee meeting. The day's business was summed up and the meeting was closed.
Close of committee meeting	