Indicator Advisory Committee Meeting

Final minutes of the meeting held on Thursday 22nd August

NICE Office, Manchester

Attendees	**Committee Members:** Daniel Keenan (DK) [chair], Richard Garlick (RG), Linn Phipps (LP), Rachel Brown (RB), Andrew Anderson (AA), Mary Weatherstone (MW), Kate Francis (KF), Elena Garralda (EG), Allison Streetly (AS), Jo Jerrome (JJ), Dominic Horne (DH), Tessa Lewis (TL) **NICE Attendees:** Craig Grime (CG), Rick Keen (RK), Mark Minchin (MM), Stacy Wilkinson (SW), Nicola Greenway (NG) and Shaun Rowark (SR) **NICE Collaborating Centre for Indicator Development (NCCID):** Andrea Brown (ABr), Jackie Gray (JG) and Paula Whitty (PW) **NHS Digital:** Gemma Ramsay (GR) **NHS England:** Clare Brenton (CB) **Expert advisor:** Campbell Cowan (CC) **NICE observers:** Rachel Gick, Judith Richardson and Nick Baillie
Apologies	Tony Kendrick, Andrew Black, Nigel Beasley, Chris Gale and Ronny Cheung

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	DH declared an additional interest in regards to his CCG role. LP updated her declarations of interest in online services in primary care, noting its expanded remit within NHS England.
Item 3 - Review of minutes and actions of March 2018 committee	MM informed the committee that the actions from the March 2018 meeting had been progressed as stated in list of actions.

Item 4 – Diabetes: review of consultation feedback	SW provided a summary of the contractual requirement for practices to identify people over 65 years with moderate or severe frailty. SW summarised the significant themes and data from the stakeholder comments received during the consultation period for proposed diabetes indicators and referred the committee to the full set of stakeholder comments provided in the papers. **IND33 Blood pressure - The percentage of patients with diabetes without moderate or severe frailty, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less.** The committee highlighted that the proposed indicator would exclude people with moderate and severe frailty, noting that this group would also benefit from controlling their blood pressure. There was debate in regards to the suggestion from stakeholders that 'batch coding' can damage the quality of the frailty data. The committee discussed how exception reporting requires thought and clinical judgement, and there should be broader acceptance of 'good' exception coding being a marker of personalised care. It was raised that the QOF review covered exception coding and looking at a change in the culture around using it. MM noted that the current QOF indicators for blood pressure targets take a 'blanket approach' for all people with diabetes – stratifying blood pressure targets based on levels of frailty would both reduce the potential for under-treatment in people with mild or no frailty and potential overtreatment in people with moderate and severe frailty. The committee recognised the benefits of IND33 but expressed concern about having no indicator for the moderately and severely frail group, suggesting that removing all indicators for this group may reduce the quality of their care. **ACTION:** Concerns were raised about progressing the indicator in its current form due to potential problems of excluding those people with moderate to severe frailty. NICE team to explore potential to progress onto menu as an addition to the existing indicators and the possibility of a similar indicator for people with moderate and severe frailty. **IND34 HbA1c - The percentage of patients with diabetes without moderate or severe frailty, on the register, in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months.** **IND35 HbA1c - The percentage of patients with diabetes with moderate or severe frailty, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months.** The committee again raised the issue that those with moderate to severe frailty are excluded from potential benefits in IND34, but recognised that IND35 provided a 'back marker'. The committee debated whether 75 mmol/mol is a reasonable target for people with moderate or severe frailty. It was noted that exceptions are a requisite of addressing precise clinical

	needs and are used by GPs when lower targets are not appropriate. The committee felt that there would need to be communication with GPs to say that frail people still need to be treated to lower targets if clinically appropriate, the care would need to be personalised. **ACTION:** The committee agreed to progress the two indicators due to the options for people with and without frailty, but with additional advice that care should be personalised and based on clinical judgement. **IND36 CVD primary prevention - The percentage of patients with diabetes aged 40 years and over, no history of CVD, and without moderate or severe frailty, who are prescribed a statin.** The committee discussed the increasing number of people deciding not to take statins that are exception reported, and other situations where exclusions are appropriate, such as for women of child-bearing potential. The committee felt that this indicator would not be looking for a 100% achievement. The evidence for excluding frail people was raised. The committee also noted that this indicator may result in people with type 2 diabetes and a 10-year risk of developing CVD of less than 10% being prescribed a statin. The committee was aware of consultation comments noting that the indicator is misaligned to the NICE guidance for assessing CVD risk and offering statins for people with type 2 diabetes. The committee concluded that indicators on primary prevention should align with the NICE guidance and be progressed as follows: undertaking a CVD risk assessment (QRISK2) and statin therapy for people with a 10 year QRISK2 score of 10% or over. The committee was aware that this would exclude people with type 1 diabetes. **ACTION:** The committee agreed to remove the frailty stratification and progress this as 2 indicators: • people with type 2 diabetes aged 20-84 years who had a QRISK2 assessment, • prescribing statins to people with type 2 diabetes and a QRISK2 score over 10% (NICE team to explore potential to reword 'prescribed' to 'offered'). **IND37 CVD secondary prevention - The percentage of patients with diabetes and a history of CVD (excluding haemorrhagic stroke) who are prescribed a statin.** The committee again highlighted the problems in the use of the word 'prescribed' and highlighted the importance of shared decision making. The committee agreed that there are not the same concerns around preventing individualised care as

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	there are with indicators IND33 to IND36. There was discussion around the intensity of statin therapy that should be prescribed and it was concluded that if possible the indicator should align with the underpinning NICE recommendation, whilst recognising that as stated in the NICE guidance some people may be prescribed a lower dose of atorvastin. **ACTION:** The committee agreed to progress the indicator – NICE team to add definition in regards to high intensity statins.
Item 5 – Atrial fibrillation: review of consultation feedback	SW summarised the significant themes and data from the stakeholder comments received during the consultation period for the proposed change to the atrial fibrillation register indicator, and referred the committee to the full set of stakeholder comments provided in the papers. The committee discussed the increased risk of stroke in people with resolved AF compared to people without AF, and the increase in numbers of cases coded as 'resolved' since AF was adopted into the QOF. The committee raised that not all people coded with 'resolved AF' will have AF, as some cases are not persistent, such as cases after cardiac surgery, or some people might have been given an incorrect AF diagnosis at their current or perhaps a previous general practice. The committee agreed that the key issue is to ensure people coded with resolved AF can have a conversation about their increased risk of stroke, and have a chance to be reviewed. The committee felt that decisions about whether to offer anticoagulation for people with resolved AF should be based on CHA_2DS_2VASc, The committee discussed whether unresolved AF is in the current NICE AF guideline, CC confirmed that it wasn't explicitly covered. MM confirmed that the issue of AF resolved has been highlighted to the guidelines team, but noted that the updated AF guideline was not expected to publish until September 2020. **ACTION:** The committee agreed to progress the change to the business rules.
Item 6 – Committee learning session: QOF review	Closed session.
Item 7 – Multimorbidity and frailty: discussion of indicators for piloting	ABr and JG from NEQOS (NCCID) summarized the work that had been undertaken to understand the resultant population size and casemix from a variety of proposed methods to construct a register of people with multimorbidity, based on the register option agreed for further exploration at the March committee.

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	NEQOS presented data for five scenarios to the committee, focusing on a scenario derived from the approach taken by the Lancet 2012 Barnett et al paper recommended for follow up by the March committee, as well as on a longer list of non-QOF conditions (to take into account omitted conditions previously discussed by the committee), and a new scenario derived from the WHO's health and ageing guidelines proposed by the National Clinical Director for Older People. For all scenarios, a clustered approach was explored as well as using individual conditions. On the basis of the analysis presented using north east primary care data, the lowest proportion of practice population that would be included in a multimorbidity register would result from using a definition based on Barnett-derived condition clusters. Using 2 or more clusters increased the proportion significantly and NEQOS advised the committee that the proportion included would be too high to be workable. Scenarios based on longer lists and clusters of non-QOF conditions produced significantly higher proportions of practice populations. The scenario based on clusters derived from the WHO's health and ageing guidelines also produced relatively low proportions; however, this scenario is based on evidence relating to older people only, and the committee requirement was to explore a multimorbidity register suitable for age 18 onwards. NEQOS also summarised expert advice received from the chair of the multimorbidity guidelines group and the National Clinical Director for Older People, noting the particular emphasis on the importance of applying clinical judgement to the final decision to include patients on a register, as counts of conditions alone would not necessarily identify people who required a tailored approach to care. While expert advice had also highlighted the potential for using polypharmacy as an additional potential method of identifying patients for inclusion, NEQOS reminded the committee of their previous work demonstrating that coding of polypharmacy was not currently adequate to use to support construction of a register. **ACTION:** The committee agreed that the multimorbidity register should be constructed by initially identifying people with 4 or more Barnett-derived condition clusters (including painful conditions). The importance of applying clinical judgement to the final decision to include patients on the register was also agreed. **ACTION:** The committee also agreed that improving polypharmacy coding should be explored. NEQOS agreed to explore further as part of piloting and testing.

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Item 8 – Alcohol: discussion of indicators for piloting	NG updated the committee with the actions from the March 2018 committee meeting on indicators for alcohol. The update focused on the remit of the committee in relation to prevention indicators, indicators on screening and brief advice that are going forward to piloting (including piloting previously piloted indicators for people with newly diagnosed hypertension using shorter screening tools) and additional areas for further discussion. **Prevention indicators for local authorities** NG informed the committee that NICE indicators measure care processes (interventions) that can be influenced by commissioning at a local level. The main focus of preventative approaches such as price regulation and marketing regulation are therefore outside the remit of the committee. The committee suggested that there may be the potential to develop an indicator on licensing as this would be delivered at a local level by local authorities (and is an example of NICE guidance that goes beyond commissioning by local authorities to include delivery) and to consider this if local authority indicators are developed in the future. **ACTION:** NICE team to record this area. **Indicators progressing to piloting – screening and brief advice** The committee were informed of the indicators on screening and brief advice for people with newly diagnosed hypertension, people with newly diagnosed depression and anxiety and people with schizophrenia, bipolar affective disorder and other psychoses (brief advice only) that are being progressed to piloting, as agreed at the March committee meeting. The committee queried the timescale for the hypertension-related indicators and why it differed from the previously piloted indicators. The NICE team agreed to check this before the indicators proceed to piloting. The committee discussed if it was appropriate to include people with anxiety in the indicators as there is currently no anxiety register. They agreed it would be clinically appropriate to screen and offer brief advice in both people with depression and anxiety and the indicator as worded should be progressed for testing and piloting. The committee queried the population for the indicator on serious mental illness and whether it matched the population on the register. The NICE team confirmed they would check if this was the case. The committee agreed all the indicators presented should go forward for piloting. **ACTION:** NICE team to check the timescales for the hypertension-related indicators and the wording of the population in the indicator on people with schizophrenia, bipolar affective disorder and other psychoses. **Screening and brief advice in people not included in NHS health checks**

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	The committee discussed two indicators on screening and brief advice for people not included in NHS health checks (people with CHD, atrial fibrillation, chronic heart failure, stroke, TIA, diabetes or dementia) and agreed these should be progressed. The committee queried whether people with obesity should be included but recognised that this indicator was focussing on people with long term chronic health conditions. They confirmed the proposed indicator included the correct conditions. The committee also discussed if the proposed 12 month timeframe for screening was appropriate or if it was too frequent and it should be every 5 years to align with the NHS health check. The committee commented that 12 months was aligned with annual reviews; however, the NICE team also agreed to check this with the chair of the relevant guidelines development group. **ACTION:** Following confirmation of the appropriate timescale with the chair of the guidelines development group by the NICE team, progress two indicators on screening and brief advice in people not included in NHS health checks based on PH24 recommendations 9 and 10. **Post screening care – follow up** The committee discussed three potential indicators on reviewing people who screened positive for unsafe alcohol consumption and received brief advice within 12 months. They agreed these indicators were important to support the person to reduce their alcohol consumption, identify if any further intervention is required and to assess the risk of alcohol related complications. The committee felt the two indicators on people with newly diagnosed hypertension and those with a long-term health condition could be implemented easily as these people would be having annual reviews and the follow up could be captured in the review. The committee recognised following up people with newly diagnosed depression and anxiety would be more challenging as they would not necessarily have annual reviews. The committee suggested it may be possible to add more information such as whether they are still being seen in primary care or on medication that would make the indicator achievable. The committee agreed all three indicators should be explored further in order to be progressed for testing and piloting. **ACTION:** Explore further in order to progress the three indicators on follow up **Early detection of alcohol-related liver disease** The committee discussed indicators on non-invasive testing for cirrhosis in people who have been drinking alcohol in a harmful way for several months and people diagnosed with alcohol-related liver disease. They agreed this was an important area as alcohol is one of the three main risk factors for liver disease and mortality from liver disease is increasing. The

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	committee were informed that these indicators were based on NICE quality standard 152 statement 3 which is developmental. This means that significant service redesign and resources are needed to implement the statement. The committee discussed how this information is coded and whether it is available to be used to measure an indicator. They also discussed at what age non-invasive testing would be offered. The committee agreed this area should be progressed and asked that further work is undertaken to explore the appropriate age range and how it could be measured. **ACTION:** NICE team to review NICE guidance to identify the appropriate age range. NCCID to explore further data variables in regards to coding and measures. **<u>Treatment and outcomes from specialist alcohol treatment services</u>** The committee discussed two areas related to treatment and outcomes from specialist alcohol treatment services, referral into the service and outcomes from treatment received in the service. The committee agreed it was important for people who may be dependent to be referred to alcohol services, this ensures they receive the support they need to reduce their alcohol use. The committee felt the proposed statement was measurable and would be based in primary care. The committee agreed to progress this indicator. The committee were informed that the National Drug Treatment Monitoring System (NDTMS) collected data on treatment (both intervention type and setting), six month outcomes (including assessment of psychological health status and self-reported quality of life) and the number of people leaving treatment and why. The committee were made aware of current indicators in this area within the Public Health Outcomes Framework and Public Health England's Public Health Dashboard. The committee agreed indicators on treatment and outcomes were important and asked for further work to be done around possible indicators on 6 month self-reported outcomes. The committee agreed not to progress any other areas such as successful treatment and waiting times as these are already being collected in other frameworks. **ACTION:** Indicator on referral to be progressed based on QS11 statement 3. NCCID to explore possible indicators on 6 month self-reported outcomes from the NDTMS.
Item 9 – Urinary tract infection – antimicrobial prescribing: discussion of indicators for piloting	The committee discussed the challenge of developing indicators in this area while the guidelines were still in development. TL, as chair of the committees developing the related guidelines, highlighted that she was aware of significant changes post-consultation, but she was unable to discuss these due to confidentiality restrictions. The committee agreed that further work was required when the published guidelines are available.

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	ACTION: Further work to be done by the NICE team on all proposed measures when final guidelines publish.
Item 10 – Review of decisions	CG and MM went through the day's discussion areas and highlighted all relevant actions that were to be taken.
Item 11 - AOB	DK thanked the committee and staff from NEQOS/NCCID, NICE and NHS Digital 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	

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