NICE National Institute for Health and Care Excellence

Indicator Advisory Committee Meeting

Final minutes of the meeting held on Tuesday 4th December 2018

NICE Office, Manchester

Attendees	**Committee Members:** Daniel Keenan (DK) [chair], Andrew Black (AB) [vice chair], Linn Phipps (LP), Rachel Brown (RB), Andrew Anderson (AA), Mary Weatherstone (MW), Elena Garralda (EG), Allison Streetly (AS), Dominic Horne (DH), Tessa Lewis (TL), Tony Kendrick (TK), Nigel Beasley (NB) and Chris Gale (CG) **NICE Attendees:** Craig Grime (CDG), Rick Keen (RK), Mark Minchin (MM), Theresa Jennison (TJ) and Paul Daly (PD) **National Collaborating Centre for Indicator Development (NCCID):** Andrea Brown (ABr), Jackie Gray (JG) and Paula Whitty (PW) **NHS Digital:** Gemma Ramsay (GR) **NHS England:** Robert Melnitschuk (RM) [AM only], Johannes Wolff (JW) [AM only] and Rachel Foskett-Tharby (RFT) **NICE observers:** Sarah Winchester, Judith Richardson and Ania Wasielewska
Apologies	Richard Garlick, Kate Francis, Ronny Cheung, Jo Jerrome

Agenda item	Discussions
Item 1 - Outline of meeting	DK welcomed all attendees and went through the planned business of the day. Apologies were noted. It was noted that recruitment of 5 standing members was in progress. Committee members were asked to share this amongst their networks and encourage applications as appropriate. ACTION: TJ to share advert and information pack for the recruitment with committee members
Item 2 - NICE advisory body declarations of interest	No new interests were declared by the committee.
Item 3 - Review of minutes and actions of March 2018 committee	The minutes were approved as an accurate record. MM informed the committee that the actions from the August 2018 meeting had all been progressed.

Item 4 – NICE Indicator Process Workshop: Summary and Feedback	CDG presented to the committee an overview of an indicators process guide workshop that took place on 2nd August 2018. The aim of the workshop had been to inform the update of the indicator process guide via discussion of six key areas. Workshop attendees included representatives from various partner organisations, IAC members and wider stakeholders within health and social care. Discussion points at the workshop included: • Methods to test and pilot general practice indicators. The current process is valued yet resource intensive; testing should be proportionate to the intended purpose. It was agreed that less intensive testing could be appropriate for non-incentivised indicators and amendments to existing indicators. However there were concerns about the development of less robust indicators. • Maintaining relevance within a changing landscape. Focus on the minimum threshold at which the indicators are feasible. • Providing national support for local quality improvement and measurement work. It was noted that national frameworks only cover limited areas of overall quality improvement and thus local schemes can be used to focus on local priorities. • Formal criteria to assess indicators. Graded quality appraisal informs the intended audience about the appropriateness of intended use, while also ensuring clarity and consistency. The publication of appraisal results for those indicators not progressed onto the menu would also help audiences understand why certain indicators did not progress to publication. • Endorsement of externally developed indicators. Potential benefits include avoiding duplication of effort and shorter time to publication. However, there was concern that indicators would not be as robust as those developed by NICE, and the process would require formal appraisal criteria. • Developing indicators based on a rapid evidence review, particularly when no, or outdated, guidance was available, or if modifying existing indicators. Again however, there were concerns about the development of less robust indicators. CDG informed the committee that all areas continue to be explored as part of the update to the process guide, however with perhaps less priority given to providing national support for local quality improvement initiatives and developing indicators based on rapid evidence reviews. It was however stated, that all discussion points will be subject to further discussion in planned workshops in January 2019. • AB then invited the committee to relay their thoughts and comments on the workshop. The committee queried whether the process guide would incorporate any principles for indicator development. CDG highlighted that NICE is out to consultation on NICE principles including social values and these would be reflected in the process guide.

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	The committee were informed that further information would be provided at the next indicators advisory committee.
Item 5 – Evidence Based Interventions (CCG)	RM and JW introduced their work which had been carried out through a national coalition of NHS England, NHS Clinical Commissioners (NHSCC), the Academy of Medical Royal Colleges (AmMRC), NHS Improvement and NICE. NHS England were exploring the development of an indicator for potential inclusion in the CCG Improvement Assessment Framework (CCG IAF). The final indicator would be supported by a series of central dashboards which would allow commissioners to access granular information on their performance. PD presented detailed analysis of the proposed indicator using Secondary Uses Service (SUS) data supplied by NHS England for the interventions and data from the NHS Business Services Authority (NHS BSA) for prescribing. Both data sets were for 2017/18. The committee noted that the indicator did highlight variation across CCGs. The cost and volume of activity for the interventions did vary significantly, with the potential for high volume/low cost interventions to skew the indicator. The low overall cost of the medicines prescribed relative to the interventions meant that a composite indicator covering both areas was driven by interventions. The committee discussed the indicator and a number of points were noted to support NHS England in taking the indicator forward: • The creation of an indicator to highlight variation and prompt local discussion and investigation was welcomed • There was some concern over use of a composite indicator but it was accepted that these were widely used in the NHS and in the context of highlighting variation to encourage further investigation of performance was appropriate • The committee suggested that there should be two indicators separating interventions from prescribing to avoid use of a 'composite of a composite' indicator and to recognise the different settings for which the indicator would impact (secondary care providers for the interventions, predominantly general practice for prescribing) • There was concern that indicators that use cost as a weighting might incorrectly suggest that the focus of the programme was cost-savings, however, it was recognised that cost did highlight the resource usage, including professional time, for each intervention. • The committee suggested that evaluation of the indicator would be valuable as there was some potential for unintended consequences. JW thanked the committee for its advice and said that they would respond to the points made to NICE by 6/12/2018. ACTION: MM to provide a formal response to NHS England

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Item 6 – Review of the QOF in England – Implications for NICE	Closed session. NHS England provided an update on policy and current work in this area.
Item 7 – Review of existing indicators – Exploratory work: Asthma	CDG introduced items 7-9 explaining that in line with proposals in the QOF review, NHS England had asked NICE to review existing indicators for asthma, COPD and heart failure to look at modifications that could help improve patient outcomes. CDG noted that the diagnostic pathways for asthma were discussed at the committee in December 2017 so did not need to be repeated in this meeting. Asthma NM101: Accurate diagnosis CDG outlined possible options to explore an indicator that required confirmation of diagnosis prior to entry on a register and expanded the age range to 5+years. The committee noted that: • This may drive improvement in accurate and objective diagnosis. • An unintended consequence could be a reduction in recorded cases compared to expected prevalence. • The current 3 month window should be explored further to see if a tighter timeframe would be appropriate. • The age range should align with the guidance. Asthma NM23: Annual review CDG outlined possible options to explore an indicator that varied the frequency of review according to stratified risk of exacerbation, and options for including additional components of a high quality review as identified by NICE NG80. The committee noted that: • People at greatest risk of exacerbation should receive more frequent review but defining these groups would require further exploration. • Additional reviews for people at risk of exacerbation could be offset by reduced reviews in people at low risk, and the committee suggested data and evidence should be explored further. • This cohort may already been seen more frequently and further exploration of this data would be of use. • Using non-adherence to medications and presence of psychosocial problems to stratify risk could cause difficulties in measurement. • Young people moving to adult services may be another cohort to explore for risk stratification. • Current QOF figures show 30% are not being reviewed and committee suggested data could be analysed to understand if these people attended emergency departments or were admitted to hospital more frequently.

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	Asthma NM102: Smoking CDG outlined possible options to explore an indicator that focused on smoking status and provision of cessation support in all people with asthma. The committee noted that: • Smoking uptake reduced with age and recommended that the evidence be explored to inform the discussion of inclusion of children under 14 and over 20. • It would be useful to encourage GPs to ask about passive smoking and noted current poor levels of coding.
Item 8 – Review of existing Indicators – Exploratory work: COPD	COPD NM103: Accurate diagnosis CDG outlined possible options to explore an indicator that required confirmation of diagnosis prior to entry on a register. The committee noted that: • This may drive improvement in accurate and objective diagnosis • An unintended consequence could be a reduction in recorded cases compared to expected prevalence. COPD NM104: Annual review CDG outlined possible options to explore an indicator that varied the frequency of review according to severity, and options for including additional components of a high quality review as identified by NICE CG101. The committee noted that: • Stratification was effective at reducing numbers requiring treatment in hospital • Patient reported outcomes be explored as a possible option • The QOF exception rate was high and varying the frequency of review according to severity might reduce it.
Item 9 – Review of existing Indicators – Exploratory work: Heart Failure	Heart failure NM116: Accurate diagnosis CDG outlined possible options to explore an indicator that required confirmation of diagnosis prior to entry on a register, and reflected timeframe more consistent with NICE NG106 and BNP results. The committee noted that: • The original timescale in the indicator had been included to prevent GPs being disadvantaged for issues outside of their control • Poor recording of heart failure in primary care following diagnosis in hospital was likely to be due to poor recording in discharge summaries. • The additional unpublished academic paper used historical data and the review should consider analysis of more recent data • There would be value in use of reported versus expected prevalence. Heart failure NM89 and NM90: Pharmacological treatment CDG outlined possible options to explore indicators that focused on up titration of medication. The committee noted that:

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	• Focusing on up titration would lead to good outcomes. • The potential for unintended consequences and the challenges of polypharmacy. • The committee noted that there would be a high exception rate but that this should be accepted.
Item 10 – Review of decisions	DK noted that the advice from the committee would be taken forward to the next stages of the process.
Item 11 - AOB	DK thanked the committee and staff from NICE and NHS England for their input today and in preparation for the committee meeting. DK informed the committee that Andrew Anderson and Tony Kendrick would be retiring from the committee and this was their last meeting. DK thanked both members for their commitment and specialist input during their membership terms noting that both had made a significant and valued contribution to the work of the committee. The day's business was summed up and the meeting was closed.
Close of committee meeting	