Indicator Advisory Committee Meeting

Minutes of the meeting held on Tuesday 5th December 2017

NICE Office, Manchester

Attendees	**Committee Members:** Daniel Keenan (DK) [chair], Andrew Anderson (AA), Nigel Beasley (NB), Andrew Black (AB) [vice chair], Rachel Brown (RB), Kate Francis (KF), Chris Gale (CG), Richard Garlick (RG), Elena Garralda (EG), Jo Jerrome (JJ), Dominic Horne (DH), Tony Kendrick (TK), Tessa Lewis (TL), Jan Norman (JN), Linn Phipps (LP), Allison Streetly (AS), Robert Walton (RW) and Mary Weatherstone (MW) **Expert adviser:** Martin Vernon (MV), NHS England **NICE Attendees:** Brian Bennett (BB), Mel Carr (MC), Craig Grime (CDG), Rick Keen (RK), Sabina Keane (SK), Mark Minchin (MM) and Judith Richardson (JR) **NICE Collaborating Centre for Indicator Development (NCCID):** Andrea Brown (ABr), Jackie Gray (JG) and Paula Whitty (PW) **NHS Digital:** Chris Dew (CD) **NICE observers – item 9:** Nick Baillie, Annie Coppel, Rachel Gick, Julie Kennedy, Rachel Neary-Jones, Shaun Rowark and Eileen Taylor
Apologies	Ronny Cheung and Simon Hairsnape

Agenda item	Discussions
Item 1 - Outline of meeting	DK welcomed all attendees and went through the planned business of the day. DK advised the committee that Professor Martin Vernon (National Clinical Director for Older People and Person Centred Integrated Care) will be joining the committee as an expert adviser for item 9. Apologies were noted.
Item 2 - NICE indicator programme update (closed session)	
Item 3 - Piloting of general practice indicators (closed session)	
Introduction to the meeting and Code of Conduct for members of the public attending the meeting	DK greeted the public attendees and went through the NICE Code of Conduct for members of the public attending the meeting.
Item 4 - NICE advisory body declarations of interest	The following committee member provided additional declarations of interest to those already registered: In relation to the agenda item on depression, TK noted that he is has an academic research interest in the area of mental health including severe mental illness. He is on the guideline development group for the NICE depression guideline and his wife is a clinical psychologist specialising in CBT.

Agenda item	Discussions
Item 5 - Review of minutes and actions of June 2017 committee	BB told the committee that the actions from the June 2017 meeting had been progressed as stated in the papers. He highlighted 2 areas for information: i. The indicators relating to breast and bowel cancer screening required some further feasibility assessment to ensure that data was routinely available at CCG level. This had since been confirmed by colleagues at NHS Digital and the indicators had therefore been submitted to the NICE Guidance Executive who approved them for inclusion on the NICE menu. ii. BB also advised the committee that the NICE team had identified a contact in relation to adding new data fields to the mental health minimum dataset (action 30 – 06/17). A letter is being sent by DK on behalf of the committee and NICE will also extend an invite to discuss opportunities for working more closely in the future.
Item 6 - NHS Digital feasibility reports	CD went through the findings of some feasibility assessment work carried out by NHS Digital: i. Action 4 – 04/16 NHS Digital to review available of data to support an indicator focused on COPD and post discharge pulmonary rehabilitation to start within 4 weeks of discharge CD advised that the data to support this indicator was last collected in March 2016 and has not been recommissioned. Unless this data collection is recommissioned by NHS England, then this indicator is not feasible. The committee agreed that this indicator cannot be progressed at the moment. ii. Action 5 – 06/17 NHS digital to review availability of data to support indicators focused on gestational diabetes when data comes online in 2017: Proportion of pregnant women with pre-existing diabetes who have a joint diabetes and antenatal care team review within 1 week of referral and The proportion of pregnant women diagnosed with gestational diabetes that have a joint diabetes and antenatal care team review within 1 week of diagnosis CD reported that the current version of Maternity Services Data Set identifies women with pre-existing diabetes or diabetes diagnosed during pregnancy, but does not record whether they had a joint diabetes and antenatal care team review, or when one happened. It is unlikely this information would be available in V2 of the data model as the review information that would be required is not currently planned for inclusion. AB asked whether the diabetes audit references if people have been seen by a joint team. CD confirmed that it did, however it didn't record when the meeting happened. AB asked whether the committee thought this would be a useful measure irrespective of timing. The committee agreed that it would like to pursue an indicator in this area. It was also suggested that we contact the leads for the audit and ask whether they could add an extra field to record the date the review happened.

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	Actions – • **NHS Digital to carry out a feasibility test using the national pregnancy in diabetes audit. Two indicators will be explored examining whether a joint review was carried out for pregnant women with pre-existing or gestational diabetes** • **NICE team to write on behalf of the committee to HQIP team to suggest a date of review to be added to the data fields for the audit.** iii. 34 – 06/16 - NICE to work with NHS Digital to look at the viability of linking the National Pupil Database (NPD) and MHSDS datasets to report educational attainment in children and young people with SMI CD advised the committee that some data fields in the NPD could potentially link the 2 datasets. However, there would need to be an appropriate legal framework that will require agreement between Department of Health and Department of Education. DK told the committee that Ronny Cheung had been in contact to apologise for not being able to attend but wanted to feedback that linking education attainment for these children and any others with long term conditions would be incredibly useful and an important measure to highlight any inequality in attainment. EG agreed with this point. **Action – NHS Digital to explore the potential legal frameworks to enable this data linkage and to feedback to the committee.** iv. Acute heart failure indicators. CD advised the committee that his team had only recently received the data from NICOR to test the feasibility of these indicators. The testing they have managed to do to date has raised some questions which will need to be answered before doing further feasibility assessment. There is a problem with regards to 2 of the indicators that refer to suspected cases, as the audit looks at confirmed diagnosis. There was some discussion about using an admission code to identify the population. DK requested that this work was progressed outside of the committee involving relevant clinical experts and the result of the feasibility assessment for all 4 indicators to be presented at a future meeting. **Action – NHS Digital to complete full feasibility assessment of the heart failure indicators and present to the committee.**
Item 7 - Severe mental illness in adults	PW introduced this topic, reminding the committee that at the June IAC it was agreed to explore the National Clinical Audit of Psychosis (NCAP) as a possible source of data for indicators in the following areas: • Treatment with clozapine • Psychological interventions • Supported employment programmes

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	- Carer focused education and support. PW wished to thank the clinical lead for the NCAP his advice and support with the work presented to the committee. PW highlighted the scope of the audit and noted the inclusion and exclusion criteria, particularly the exclusion of Early Intervention in Psychosis (EIP) services. PW advised the committee that the current round of data collection is the last retrospective audit. From 2018, the data will be collected prospectively and new populations and data fields will be added. For example, currently the audit does not include people with bipolar disorder, however the 2018 prospective audit will. The committee noted this and agreed to revisit the indicators for people with bipolar disorder when the audit has been extended. In terms of the NCAP providing CCG level data, the audit seeks to have a sample of at least 50 people per CCG. If returns are too low they may not publish some data items at CCG level. This will not be possible to assess until June 2018 when the audit data are available. The committee agreed to wait for this to happen to assess the potential of CCG level indicators being supported. **Indicators for review** *i. The proportion of adults with schizophrenia that have not responded adequately to treatment with at least 2 antipsychotic drugs (at least 1 of which should be a non-clozapine second generation antipsychotic) who receive clozapine* PW reported that this indicator is not currently supported by the NCAP. The current retrospective audit would only support a simpler indicator on the number of people with a diagnosis who were not in remission or only partially in remission who were prescribed clozapine. PW advised the committee that the more complex indicator should be supported once the prospective audit is in place. The committee were asked whether to proceed with the simplified indicator using the current audit or wait for the prospective audit data to be available to support the more complex indicator. The committee noted that the more complex indicator more closely reflects the quality statement. **Action - the committee agreed to wait for the prospective audit in 2018 in order to review whether the indicator above could be progressed** *ii. Proportion of adults with psychosis or schizophrenia who receive cognitive behavioural therapy for psychosis (CBTp)* PW advised that there are 2 potential indicators that the NCAP could support:

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	a) Proportion of adults with psychosis (ICD codes as defined in NCAP) who have been offered Cognitive Behavioural Therapy for Psychosis (CBTp) by a suitably qualified therapist. b) Proportion of adults with psychosis (ICD codes as defined in NCAP) who have been offered Cognitive Behavioural Therapy for Psychosis (CBTp) by a suitably qualified therapist, who have taken up the offer of CBTp These data will continue to be collected in the 2018 prospective audit. Committee members agreed that it would be useful to progress these indicators. EG noted that there are some gaps in availability of this treatment and these indicators could support wider provision. TK highlighted that there would need to be a clear definition of what was meant by '*taken up the offer of'* treatment, ensuring that this meant they had stayed in the treatment programme for sufficient time. PW agreed this was important and referred to the data collection tool and underlying treatment manuals which provided more detail on this definition. **Action – the committee asked for these indicators to be taken forward** iii. *Proportion of people with psychosis or schizophrenia who have arrangements for accessing education or employment related training included in their care plan* PW advised the committee that after reviewing the NCAP the indicator would not be feasible, however there was a potential alternative: *Proportion of adults with psychosis (ICD codes as defined in NCAP) who are currently unemployed and seeking work, who have been offered employment or vocational support programmes, or apprenticeship or education programmes.* AA flagged to the committee that the denominator for this indicator would only include those in touch with secondary mental health services as that is the scope of the audit. PW accepted that this is a potential issue and would exclude those who are stable, if they are being treated in primary care and not currently in touch with secondary care services. NB suggested that the NICE team check with the QS committee whether they intended for the quality statement to focus only on those in secondary care. EG suggested that measurement on an annual basis is likely to cover the majority of people with SMI as many will be in contact with secondary mental health services at some point. AB summarised discussions, noting that this is a pragmatic approach and that we should go forward with the revised indicator noting the issue around this indicator excluding those who are not in contact with secondary care services. **Action – the committee asked for the amended indicator to be taken forward**

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	iv. *Proportion of adults with psychosis or schizophrenia whose carers receive a carer focused education and support programme.* PW advised the committee that data for this indicator could not be sourced from the NCAP or the MHSDS. LP noted previous audit data showed the lack of support for carers of people with mental health problems, but that this data collection has not been repeated. JN highlighted that a lot of carer support is funded and commissioned by local authorities who are under significant financial pressure and therefore services for carers are probably suffering. AB noted that without existing data collection in place this indicator cannot be progressed. v. Outcome indicators for people with SMI *Relapse rates of schizophrenia in adults;* *Relapse rates for adults with bipolar disorder;* *Hospital admission rates for adults with bipolar disorder;* *Employment rates among adults with SMI;* *Quality of life for carers of adults with psychosis* PW, the NCAP clinical lead and colleagues had reviewed the NCAP in relation to the above outcome measures. PW confirmed that the audit could support an indicator focused on employment rates, noting the earlier caveat that the denominator would only include those in contact with secondary care. DH asked to check whether the audit included those 16 and over and therefore measured engagement in education. TL supported this as a hard outcome measure. MM noted that there is a very similar indicator to this in the CCG OIS based on the mental health service dataset (MHSDS). DK suggested that the proposed indicator and the one included in the CCG OIS are compared to see whether they may cover similar populations. PW agreed to review this but did note that the MHSDS has poor diagnostic coding whereas inclusion in the NCAP is based on diagnostic codes. **Action – PW and team to compare the proposed indicator against the current CCG OIS indicator focused on employment.** Two other outcome indicators were suggested: *Proportion of adults with psychosis (ICD codes as defined in NCAP) for whom a Health of the Nation Outcomes Scale (HoNOS) has been completed in the last 12 months, who have engaged in self-harming behaviour.* *Proportion of adults with psychosis (ICD codes as defined in NCAP) for whom a Health of the Nation Outcomes Scale (HoNOS) has been completed in the last 12 months, who have problems with living conditions*

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	The committee discussed the potential benefit of an indicator on self-harming behaviour as it can be associated with increased risk of suicide. However, a number of committee members expressed concerns around the utility of these indicators, the definition of the denominator and the interventions that would be markers of quality improvement. PW confirmed that the indicator denominator would be all those with psychosis as per the audit inclusion criteria who have had the HoNOS completed. MM advised the committee that NICE are currently developing a new guideline on prevention of suicide and therefore suggested that we do not progress any indicators in this area at the moment, but review the new guideline when it is published to help identify potential indicators. **Action – NICE team to bring a paper to the committee based on the NICE guideline on suicide prevention to a future meeting** vi. Family interventions PW noted that in the original paper that went to the June 2017 committee concerning adults with SMI there was no reference to the NICE quality statement 3 from NICE QS 80 concerning family intervention. The committee agreed that if there was a potential data source for an indicator in this area that it should be progressed. PW confirmed that the NCAP would provide a suitable data source and that similar indicators to those agreed for CBTp could be developed. **Action – NICE team to check if there were any issues with this area and if not, this area to be progressed for further development**
Item 8 - Asthma	MC provided the background to this topic. The committee had first reviewed the draft NICE asthma guideline in 2015 and made recommendations about changes to current indicators and suggestions for new indicators. However, the publication of the guideline was then delayed. MC noted to the committee that the NICE guideline on the diagnosis, monitoring and management of chronic asthma (NG80) published in November 2017 highlighting that there have been changes to some of the recommendations since the committee reviewed an earlier version of the guideline in 2015 and therefore the committee was asked to review the proposed indicators against the 2017 guideline. i. QOF asthma register Current QOF register (AST001) - *The contractor establishes and maintains a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the preceding 12 months*

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	Proposed new register - *The contractor establishes and maintains a register of patients, aged 5 or over, with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the preceding 12 months* The committee were asked to confirm that they were happy for the addition of an age range from 5 to be added to the register, reflecting the new NICE guideline. The committee agreed that the proposed amendment should be progressed for consultation. **Action – amended register to be taken forward for consultation by the NICE team** ii. Asthma diagnosis Current QOF indicator (AST002) - *The percentage of patients aged 8 or over with asthma (diagnosed on or after 1 April 2006), on the register, with measures of variability or reversibility recorded between 3 months before or any time after diagnosis* MC told the committee that the new recommendations in the guideline concerning diagnosis of people with asthma had led to a number of concerns being raised by stakeholders about the availability of the referenced tests. The guideline includes a joint statement from NHS England and NICE recognising that the investment and training required to implement the guideline will take time. MC therefore asked the committee whether, in the interim, the current indicator (AST002) should be retained with a minor amendment to lower the age range from 8 years to 5 years and over. MC then suggested that the NICE team can do some further work using the new guideline to develop indicators focused on diagnosis, allowing time for the asthma guideline (NG80) to be embedded into practice. AS suggested that if the supporting information provided on the website should make clear that AST002 will be under annual review. The committee agreed and that work should start on the new indicators. **Action - The committee agreed to retain AST002, but to go out to consultation on the proposed change from 8 to 5 years and older. The NICE team to review uptake of NG80 with a view for starting to develop indicators based on the new recommendations.** iii. Asthma review Current QOF indicator (AST003) - *The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions* Following a review of the draft guideline in 2015 2 new indicators were proposed to replace the current indicator:

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	NM137. The percentage of patients with asthma, on the register, aged 16 years or over who have had an asthma review in the preceding 12 months that includes an assessment of asthma using either spirometry (FEV1) or peak flow measurement, assessment of inhaler technique and use of a validated asthma control questionnaire *NM138. The percentage of patients with asthma, on the register, aged 5 to 15 years who have had an asthma review in the preceding 12 months that includes an assessment of asthma control* The guideline published in 2017 had removed reference to a validated asthma control questionnaire and had amended the age ranges from 5-16 years and 17 years and over. The committee were asked to consider the removal of the reference to a validated asthma control questionnaire from NM137, to amend the age ranges and to review whether the wording for NM138 should specify the content of the assessment. AB suggested that if the guideline no longer references a validated questionnaire then it should be removed from the indicator. AA suggested that if the validated questionnaire is removed from NM137, the 2 indicators could be combined. TL suggested that if the 2 indicators were merged it would be important to get feedback via consultation from clinicians concerning the proposed changes. AB suggested that the wording of NM137 is used for all ages (5 and over), but ending at "…..assessment of inhaler technique" and that NM138 is therefore not progressed. The committee agreed to this and confirmed the indicator should go out for consultation. **Action – NICE team to take amended indicator out for consultation**
Item 9 – Multimorbidity and frailty	AB introduced Prof Martin Vernon (MV), NCD for Older People and Person Centred Integrated Care at NHS England. MV presented current approaches at NHS England to meet the needs of people with frailty and linking that with the wider work on multimorbidity. MV highlighted the increased demand on services and the large number of patients who are living longer but with more complex needs. The intention is to focus on a preventative and integrated model of care. Committee members thanked MV for his presentation. There was a discussion about the importance of trying to maintain independence in people with frailty and whether at a population level the trajectory for frailty can be reversed. The discussions then led onto the presentation from NCCID colleagues concerning the proposed indicators for multimorbidity and frailty.

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	i. Registers ABr gave an overview of the work her and colleagues had done to date investigating the cross over between the frail population and those with multimorbidity. Following a review of the literature, discussions with IAC members, other GPs and a review of existing data their recommendation is that there should be a register for both multimorbidity and frailty, recognising the overlaps MV was asked his opinion and he confirmed that he agreed with the recommendation to progress 2 registers. He acknowledged that there would be some crossover and there are overlapping interventions. The committee discussed this proposal and agreed that while there may be some crossover between the 2 populations, they were distinct groups. The committee also agreed that the definition of the frailty register would be as for the GP contract i.e. people with moderate and severe frailty. **Action - The committee to take forward 2 separate registers.** ii. Multimorbidity register ABr then presented the options for the multimorbidity register population: a) *multimorbidity (defined as those with at least 2 long term defined or ongoing health conditions and at least one symptom complex or impairment as identified in NG56)* b) *multimorbidity* (defined as those with at least 2+ QOF or defined non-QOF conditions), and either: i. have impaired physiological function ii. are being prescribed 10+ regular medications iii. have had 2+ unplanned hospital admissions in the last 12 months, or iv. are permanently resident in a care home PW explained that the intention of both options is to make the register more focused than using 2 or more long term conditions alone, by introducing a greater recognition of complexity and thereby a greater likelihood of benefiting from a tailored approach to care. The committee had a discussion about the pros and cons of each option. Option a) was deemed to be more in line with the guideline recommendations but could include a much larger population. There was recognition that the business rules for option b) would be much more complex and could affect the feasibility of the indicator. AB noted that whatever option is progressed clinicians will still need to have the option to manually add people that in their view should be on the multimorbidity register and consideration will also need to be given to what conditions should also be included where there isn't a current QOF register.

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	AB summed up the discussion. It was agreed that some further work was required to refine the multimorbidity register and that NCCID colleagues should be tasked with looking at what the population differences might be between the 2 different registers. **Actions:** • **NCCID to report back to the committee the outcome of work looking at the potential percentage of practice populations that would be included in both register options for multimorbidity** • **NCCID to identify what non-QOF long term conditions should also be included** iii) Medication reviews ABr presented the discussion points on an indicator focused on medication reviews in the 2 populations. Feedback from IAC members when developing the options included the need for face to face meetings, guidance notes about what should be included in the review and also the potential role of pharmacists. The committee were asked to consider the following indicator: *The percentage of patients with frailty and/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* LP supported the inclusion of this indicator and that it was important that consideration was given to the content of the review to ensure that it isn't a tick box exercise. MW also supported this indicator and referenced the national work happening at the moment looking at the role of pharmacists working in practices and also care homes supporting medication reviews. RG referenced the "Year of Care" work that provided an example of the potential content of a review, which in this case goes beyond just medication. DH agreed with this and suggested that it would be useful to broaden out this indicator to include additional factors beyond medication. AB summed up discussions and confirmed that the committee agreed that an indicator that includes medication review should be progressed and that NCCID colleagues should include factors beyond a medication review in the guidance notes. **Action – NCCID to further develop the above indicator concerning medication review and to also include reference to other factors in the accompanying guidance.** iv) Falls prevention ABr went through the discussion points in relation to potential indicators on fall prevention in people with moderate or severe frailty. Three potential indicators were proposed:

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	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 *b) The percentage of patients (aged 65 years and over) with moderate or severe frailty who have 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)* *c) The percentage of patients (aged 65 years and over) with moderate or severe frailty who have had a falls risk assessment and if at risk, who have been referred to a falls clinic / prevention services (as clinically appropriate) in the last 12 months* MV highlighted the capacity issues concerning falls prevention services nationally and that this would need to be taken into consideration when implementing any indicators in this area. DH asked what indicator a) would add if indicator b) went forward. AA agreed and suggested all 3 indicators could be amalgamated. AB suggested that a) and b) could be but that indicator c) was a subset of the denominators from the other indicators. **Action – the committee agreed to combine indicators a) and b) and also take forward indicator c) for further development** v. Outcome measures ABr highlighted the potential outcome measures discussed by the committee at the June meeting: • Unplanned admissions • Length of stay • Delayed transfers of care • Readmissions • Return to usual place of residence following a hospital admission NCCID colleagues had done some exploratory work looking at potential outcome indicators for this population, in advance of agreement about the denominator register population. While there are some indicators in national frameworks reflecting these areas, there aren't any specific to the population we are currently looking at. The team had looked at HES using a 'convenience sample' in the absence of a register definition and suggested 3 possible areas that could be explored further:

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	• Unplanned admissions • Length of stay • Readmissions The committee noted that these outcome measures would require data linkage between the primary and secondary care data. The outcome measures may not be appropriate at GP level, but NB suggested that having these type of indicators for secondary care would be useful. There needs to be greater awareness amongst secondary care clinicians about people with frailty. CG suggested that if a HES code for frailty was developed, an outcome indicator could be developed. AA drew the committees attention to the data NCCID colleagues had included in the briefing paper showing the significant regional variation in unplanned admission rates. AB summed up discussions, the committee agreeing that these proposed outcome indicators should be progressed once the register definitions are finalised, with further exploration of the process required to link primary and secondary care data. **Action – NCCID to progress proposed outcome indicators once the register definitions are finalised and look at data linkage requirements.**
Item 10 – Depression (Closed session)	
Item 11 – Review of the days business	DK thanked the committee for their contribution to the day's discussions. The committee fed back that they thought the day had been productive and that supporting papers had been useful to help inform the discussions. DK then closed the meeting.
Close of committee meeting	