Indicator Advisory Committee Meeting

Draft minutes of the meeting held on Tuesday 6th June 2017

NICE Office, Manchester

Due to the nature of the day's business and the current period of purdah, this meeting was held as a part 2 meeting and therefore closed to the public

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), Elena Garralda (EG), Simon Hairsnape (SH), Dominic Horne (DH), Tony Kendrick (TK), Tessa Lewis (TL), Jan Norman (JN), Linn Phipps (LP), Allison Streetly (AS), Mary Weatherstone (MW) and Paula Whitty (PW). **NICE Attendees:** Brian Bennett (BB), Gavin Flatt (GF), Craig Grime (CG), Mark Minchin (MM) and Shaun Rowark (SR) **NICE Collaborating Centre for Indicator Development (NCCID):** Paramjit Gill (PG), Rachel Foskett-Tharby (RFT), Nick Hex (NH) & James Mahon (JM) **NHS Digital:** Pam Murray (PM) and Chris Dew (CD) **Invited observers:** Linda Issot – NHS England, Raechel Newell – NHS Employers, Imke Jahner – RCGP & Andrea Brown North East Quality Observatory Service
Apologies	Emily White, Chris Gale, Robert Walton & Jo Jerrome

Agenda item	Discussions
1. Outline of meeting	DK welcomed all attendees to the meeting. He noted that due to Purdah the meeting will be held in private with a small number of invited observers. DK advised the committee that the primary business of today's meeting was to review the outcomes from testing, piloting and consultation for a number of indicators previously discussed at the committee. Apologies were noted.
2. NICE programme update	MM provided the committee with an update about some organisational changes at NICE. The name of the programme within which the indicator team is based is now called the Quality and Leadership programme. Craig Grime was introduced to the committee as the new technical lead for the programme. MM also advised that the NICE have been going through a retendering process for the Indicator Collaborating Centre. Following interviews of prospective applicants, the contract has been offered to the North East Quality Observatory Service, with contract negotiations currently underway. MM took this opportunity to formally thank colleagues from the current NCCID for all the work they have done to support the NICE indicator programme and wished them well for the future. DK also added his and the committees thanks to colleagues from the current NCCID. MM went through some work the indicator team have been doing with colleagues at Cheshire and Merseyside to develop an indicator package to support quality improvement work focused on hypertension. MM explained that NICE see this as a useful alternative use for the indicators currently on the NICE menu in addition to their use in national indicator frameworks. MM also provided an update concerning the current review of the QOF. This was agreed as part of the contract negotiations for general practice for the 2017/18 GP contract. MM advised that the committee will be kept up to date as the review progresses and that the work of the committee continues and NICE will be working with NHS England during the review.
3. NICE advisory body declarations of interest	The following committee members provided additional declarations of interest to those already registered: NB – advised that he has recently started a new role at Sheffield Children's NHS Foundation Trust. TK – advised that he is involved in current research looking at the impact of the QOF EG – advised that she has a non-specific financial interest as she shares in a pharmaceutical company AB – advised that his practice has been involved in the piloting of the diabetes prevention programme work

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4. Review of minutes and actions of June committee	DK asked the committee to review the minutes and highlight any inaccuracies and omissions. The committee ratified the minutes as accurate BB went through the actions table from the previous meeting. He advised that the majority of actions will be covered during the next 2 days business. He did provide some specific updates: <u>Valproate prescribing</u> The NICE team have reviewed a potential data source for an indicator focused on the use of valproate for the treatment of severe mental illness in women of child bearing potential. The team have been in touch with RCPsych who carried out an audit looking at the use of valproate in women. Colleagues at RCPsych advised that this was a pilot audit and was somewhat experimental. The potential for repeat audits is unclear. **Action** - It was therefore agreed that the NICE team would monitor the future of this audit and if this is progressed, that the potential for an indicator in this area can be revisited. <u>10 week antenatal appointment</u> BB advised that it has now been possible for NHS Digital to do a full feasibility assessment of this indicator as data are now available through the maternity services data set. The feasibility assessment showed that 48,958 booking appointments were recorded in December 2016, with 55.5% of women attending a booking appointment within 10 weeks. Therefore the committee noted that there was sufficient numbers and need for improvement for this indicator to be worth progressing. **Action –** The committee recommended this indicator for inclusion on the NICE indicator menu as a CCG indicator. <u>Sepsis</u> BB advised that there will be further work to look at potential indicators focused on sepsis whilst the national coding standard for sepsis is implemented. <u>Antibiotic prescribing</u> TL asked for an update on work concerning potential indicators focused on antibiotic prescribing. RFT updated the committee that she has been in discussion with TK and one of his colleagues. RFT advised that the main difficulty in developing indicators in this area is that a number of the indicators would need to use a denominator which would be people with suspected conditions. It is very difficult to develop a rigorous clinical ruleset focused on suspected codes. TL told the committee that she is chairing the current NICE committee on guidance for infectious disease. **Action** - AB summarised discussions and suggested that the NICE team review the output from the infectious disease work and see whether there is potential to develop any indicators from this work.

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	Long term actions LP highlighted that the NICE team had confirmed that they hold a long term action list of indicators that the committee have discussed but for various reason further action is on hold and that it had bene agreed that this list would be shared with the committee. BB confirmed that after this meeting, any indicators in this situation would be added and the list would be circulated to colleagues.
5. Update on indicator development process and decision options for the committee	BB gave the committee an overview of the indicator development process, reminding them that today's business will be focused on reviewing the outcomes from piloting / feasibility testing and consultation. The committee were advised that for each indicator under discussion there would be 3 main decision options: 1. Recommend for the indicator menu 2. Further work is required 3. Cease development work
6. Pulse rhythm assessment and atrial fibrillation anticoagulation	(AB chairing the morning's business) ***i. Piloted indicator - The percentage of patients registered at the practice aged 65 years and over who have been diagnosed with one or more of the following conditions: hypertension, diabetes, CKD, PAD, stroke/TIA, COPD or RA who have had a pulse rhythm assessment in the preceding 12 months.*** SR went through the background to this indicator. This indicator went out to consultation in 2016 and was supported by the committee for further work. It was therefore agreed not to review the consultation comments again. RFT went through the results from piloting. This indicator was well supported by participants in the pilot and had only minor implementation issues. There was a question about whether people on the CHD register should be included in the target population for this indicator. Variations were reported amongst piloting sites about how pulse recording was recorded on systems with some doing this via free text boxes. Some concerns were raised about potential workload implications if this indicator was implemented. The potential for this indicator to be seen as screening was also flagged by some during piloting. JM explained the assumptions used for the cost effectiveness assessment and advised that the indicator was highly cost effective. MM advised the committee that NICE had been in contact with colleagues at the National Screening Committee who were happy that this was not screening.

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	NB asked about the evidence base for the inclusion of RA and COPD and the current exclusion of people with CHD. It was confirmed that the inclusion of COPD and RA came from external guidance and evidence, but they are not currently referenced in NICE guidance as requiring blood pressure monitoring. NB suggested that if there is no NICE evidence we should remove COPD and RA and include CHD. TL agreed that the indicator should align with the NICE guidance. There was some discussion about whether people with CKD should be included, as this will be a large number of people and if excluded would make the indicator more focused. AB noted that not including people with CKD could miss some important cases of people with AF and that this population should be included. The committee agreed that the coding for this indicator should be straight forward, that clinicians should routinely be assessing pulse rhythm with this population and that the indicator has been shown to be highly cost effective. <u>Recommendation</u> The committee agreed that the indicator should include people with CHD and those with heart failure, but that people with RA and COPD should be excluded. The indicator in this format was then recommended for inclusion on the menu. <u>ii.</u> Piloted indicator ***The percentage of patients with atrial fibrillation, currently treated with an anticoagulant, who have had a review in the preceding 12 months which included:*** ***a) Assessment of stroke/VTE risk*** ***b) Assessment of bleeding risk*** ***c) Assessment of renal function, creatinine clearance, FBC and LFTs*** ***d) Any adverse events related to anticoagulation*** ***e) Assessment of compliance*** ***f) Choice of anticoagulant*** SR went through the background to this indicator. This indicator went out to consultation in 2016 and was supported by the committee for further work. It was therefore agreed not to review the consultation comments again. RFT advised the committee that this indicator had strong support from practices involved in the piloting work and only minor implementation issues were referenced. There was an issue flagged concerning responsibility for monitoring patients who are on anticoagulants as in some areas this is done in secondary care and in others this is done in primary care.

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	JM advised that carrying out a cost effectiveness assessment was complicated. The key assumption used was based around treatment compliance. Annual reviews with patients have been shown to improve medication compliance. Using this as the key outcome, and assuming that the review would move a proportion of people from non-compliant behavior to compliant, this indicator would be cost effective. However, there are challenges with this, as it assumes people who are taking medication not as directed are receiving no medical benefit – i.e. classed as untreated. The committee discussed the outcome from piloting and cost effectiveness assessment. AA supported the indicator and said it is entirely appropriate for people in this population to attend annual reviews. He did ask whether it was necessary to calculate a CHA_2DS_2-VASc score annually as these generally don't go down. AB suggested it was important that they were monitored as it can go up. DH asked why time in therapeutic range for people on warfarin was not also included. AS advised that this information is not routinely available at a national level. AA asked whether this should just be a general practice focused indicator as some patients would attend warfarin clinics in secondary care. Committee members agreed that whilst this was the case it would still be important to conduct reviews in general practice. **Recommendation** The committee agreed to recommend this indicator for inclusion on the menu and that there should be reference in the guidance notes that reviewing a patient's time in therapeutic range should also be considered.
7. NHS Diabetes Prevention Programme	The NDPP indicators were discussed at the same time, so the outcomes from consultation for all indicators and the piloting work were presented together before the committee discussed the indicators. <u>Piloted indicator</u> ***i. GP8: The practice establishes and maintains a register of all people with a diagnosis of non-diabetic hyperglycaemia (NDH).*** GF advised the committee that the NICE guideline (PH38) that underpins the diabetes prevention indicators is currently being reviewed. The group deemed to be at high risk of developing diabetes has been reviewed in the draft updated recommendations. The current group, those with a fasting glucose level of 5.5 – 6.9 mmol/mol or HbA1c of 42-47 mmol/mol are still identified as high risk. However the first draft of new guideline updates suggests that those with a fasting glucose of 6.5–6.9 mmol/l and HbA1c of 44 to 47 mmol/mol (6.2-6.4%) should be prioritised for referral to intensive lifestyle-change programmes. This potential update does not really impact on the proposed indicators as the register is likely to remain as previously proposed. If required a separate extraction could be performed to get a subset of the register.

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	GF went through the consultation comments received about this indicator. Concerns were raised about the potential workload implication if this register was implemented. There were some concerns about a one size fits all approach to supporting people with NDH, as people's circumstances vary and some issues were flagged with potential safety issues for some frail older people who are encouraged to reduce their blood glucose too quickly. The evidence base for interventions in this population having a beneficial clinical impact were questioned Piloted indicator ii. ***GP9: The percentage of people newly diagnosed with non-diabetic hyperglycaemia in the preceding 12 months who have been referred to a Healthier You: NHS Diabetes Prevention Programme for intensive lifestyle advice***. GF went through the consultation comments. There was concern raised that a national programme may deter good local practice from continuing. Some stakeholders questioned the evidence that intensive lifestyle advice results in an improvement in patient-centred care. The ability of all people identified as having NDH being able to commit to attending an intensive lifestyle programme was questioned due to practical issues. Piloted indicator ***iii. GP10: The percentage of people with non-diabetic hyperglycaemia who have had an HbA1c or FPG test in the preceding 12 months*** GF went through the consultation comments. Some stakeholders questioned the 12 month timeframe for the repeat HbA1c testing. The potential workload implications repeat testing could have for general practice and pathology laboratories was identified as a consideration. Retaining the engagement of patients in repeat testing was also flagged as a potential issue. RFT went through the key themes from the piloting of these 3 indicators. She informed that committee that as these indicators were focused on a new national programme that is currently only implemented in a sub set of CCG's it was agreed some additional work would be done testing these indicators in an area that is an early adopter site. Therefore 4 additional practices were involved in the piloting from a CCG where the programme is in place. The register and HbA1c testing indicators were relatively well received by all piloting practices. The indicator focused on referring to the NDDP service had low acceptability levels amongst the general piloting group. However, it was noted that amongst the early adopter sites there was high levels of support for the indicator. There were no major implementation issues flagged.

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	Six patient focus groups were held in the early adopter sites for people identified as having NDH. Feedback from the focus groups included surprise at the idea of any of the proposed indicators being part of an incentive scheme, suggesting that this should be part of routine care. There was concern about the NDPP being the only option for people. JM went through the cost effectiveness assessment of the referral indicator. The other indicators were not assessed. The cost effectiveness assessment found that the referral indicator was highly cost-effective. This was based on an assessment of lifetime costs that would arise from delivery cost of intervention and treatment for diabetes, offset by reduction in CVD and other conditions. The QALY gains were based on reductions in diabetes related conditions. The committee discussed the register first. AA asked whether there should be an upper age limit so very elderly people are not included in the register as in many cases they would have a raised HbA1c level and wouldn't necessarily benefit from a referral for lifestyle interventions. AB suggested it would be better to have people on the register and then use professional judgement in collaboration with the person to decide whether it would be useful to refer them. RC also flagged that NICE guidance does not suggest an upper age limit and therefore we should stay in line with that. RB suggested that establishing this register will potentially save time for GPs as at the moment people with NDH, it isn't always clear how to manage them. This will give a clear pathway for people. **Recommendation - register** The committee agreed to recommend this indicator for inclusion on the NICE indicator menu The committee then discussed the indicator concerning referral to the NHS Diabetes Prevention Programme. The committee noted that the difficulty with this indicator as this this service is not yet available nationwide, with full roll out due by 2020. It was suggested that this indicator could be held on the menu and that it could be implemented once the service was fully rolled out. RC asked whether any intervention in this population should be focused on self-care rather than referring people to interventions. AA asked whether the indicator could be about referring people to self-help groups. SH asked whether it could be less prescriptive and be more about referring people to a service rather than just the NDPP. **Recommendation - referral** The committee agreed to recommend the indicator focused on referral to the NDPP for the menu, noting that it would not be suitable for implementation nationally until the service has been fully rolled out. The committee also asked the NICE team to look at the potential of developing a separate indicator based on referral to local lifestyle support services. The committee then discussed the indicator concerning repeat HbA1c testing in people on the NDH register. The committee agreed that this was a sensible care process to perform in this population.

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	Recommendation – repeat HbA1c testing The committee agreed to recommend this indicator for inclusion on the NICE indicator menu.
8. Gestational diabetes	Piloted indicator ***GP3 – The percentage of women who have had gestational diabetes, diagnosed more than 12 months ago, who have had an HbA1c test in the preceding 12 months*** GF advised the committee that this indicator was consulted on in 2016 and was reviewed by the committee in June 2016, where the indicator was supported and recommended for piloting. RFT went through the outcomes from piloting. The indicator was relatively well supported by piloting practices, with only minor implementation issues. A key question was about whether this test was required on an annual basis and whether an end point should be included for then the testing should stop. RFT also advised that there were small numbers at individual practice level with this indicator. AA asked whether a longer time scale between reviews could be considered. PW highlighted that the NICE guidance is clear on this that there should be an annual review in this population and that there is no end point for this testing as the women will remain at risk. AS suggested that if numbers were particularly low, data could be aggregated up to CCG level. AA asked whether the register for this population should be retrospective and prospective so women who had gestational diabetes previously are added to the register. This was agreed by the committee. TK made the point that logistically an annual review was easy to do and if number aren't particularly high then this should be easily done. **Recommendation** The committee agreed to recommend this indicator for inclusion on the NICE indicator menu.
9. Acute kidney injury	The AKI indicators for general practice were discussed as a set Piloted indicators ***GP1 – The practice establishes and maintains a register of all people aged 18 years and over with an episode of AKI in the preceding 12 months.*** ***GP2 – The percentage of people with an episode of AKI in the preceding 12 months who have had a serum creatinine, eGFR and either an ACR or PCR recorded within 3 months of the record of diagnosis*** ***GP3 – The percentage of people aged 18 years and over with an episode of AKI in the preceding 12 months who have had a medication review within 1 month of the record of diagnosis.***

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	GP4 – The percentage of people with an episode of AKI in the preceding 12 months who have been given written information about AKI within 1 month of the record of diagnosis SR went through the comments from consultation. A key concern raised for all the AKI focused indicators was about hospital discharge letters being sent in a timely manner and accurately recording the diagnosis of AKI. Some issues were raised about IT systems being able to set up automated alerts for AKI. The lack of a recognised, consistently used code set for AKI was identified as a potential issue. The fact that the indicator could lead to an increase in workload was also flagged. Some stakeholders also questioned whether the age limit was appropriate. There were a number of comments that the action described in these indicators should be carried out within secondary care, when the diagnosis is made. RFT went through the outcome from piloting. The indicators had relatively low levels of support from participating practices. Whilst they felt that it was an important clinical area to focus on, they questioned whether systems were in place to enable this register and associated indicators to be established in a robust way. A key issue identified was lack of consistency in discharge letters coming through to GPs with accurate recording of AKI in line with comments from consultation. AB agreed with the issues flagged about inconsistency in reporting on AKI from secondary care. Sometimes it is referenced as a secondary diagnosis or sometimes it is not referenced at all. DH asked whether the implementation of the register and any associated indicators could improve reporting from secondary care to primary care. DK advised the committee that there is a national focus on improving discharge communication between secondary and primary care. NB advised that there is a focus on the identification and treatment on AKI in secondary care and this could prompt GPs to request clearer information from secondary care services in their area. AA suggested that it was a good idea to have the register and that it should be based on the date of diagnosis, wherever that diagnosis was made. The committee discussed whether the register should include all people who have had a diagnosis of AKI rather than just focusing on those who have had it in the last 12 months. The reason for this was that if someone has had AKI they are at risk of future events, so the register could be useful to flag potential issues when treating people for other conditions in the future. RFT suggested that the indicators are focused on current care and therefore it wouldn't include all people in the denominator for the intervention indicators. DH suggested that the register included all and that any extraction can be written to pull out specific groups from the register such as those who have had AKI in the last 12 months. RC requested that if the register is going to include all those with AKI that there isn't a lower age limit. This was agreed by the committee. The committee discussed GP 2 and GP 3. The timings for both depended on when the diagnosis was recorded. Some areas code the date of diagnosis, others record it as the date of discharge. GP 3 is complicated by cases where the diagnosis was made in hospital and if the patient has a long in-patient stay, the 4 week timeframe may occur whilst they are

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	still in hospital and their review should happen in hospital. Therefore the indicators may be relevant at both secondary and primary care. The committee agreed this and suggested that further thought is given to this. The committee discussed GP4. It was agreed that provision of information following a diagnosis of AKI would most likely occur in secondary care, not primary care. **Recommendation** DK summarized the discussions and the recommendations from the committee. The committee agreed to recommend the development of a register for all patients diagnosed with AKI. The committee asked that the NICE team l to review GP2 and GP3 to see whether they would work on a locality basis incorporating primary and secondary care. The committee recommended that GP4 was not taken any further.
10. Autism and learning disabilities	<u>Piloted indicator</u> ***GP5 – The practice establishes and maintains a register of all people on the autistic spectrum*** SR went through the consultation comments for this register indicator. There was a lot of support for the indicator, particularly amongst organisations representing people with autism. The implementation of a register was deemed to be an opportunity to establish a more consistently used code set for autism. It was noted that at this stage this is just a register and that further indicators should be develop which focus on care processed. The accuracy of the register may be affected by inconsistent sharing of diagnostic information from relevant services with general practice. RFT went through the outcome from piloting. This indicator had low support amongst participating practices, who felt that they were aware of their patients with autism and were unsure what value a register would provide. For those diagnosed with autism there is an issue in that there a very few services to refer people to. The overlap with the current learning disabilities register was also flagged. AA highlighted the importance of having indicators in addition to the register, so it can have an impact on improving care and outcomes for this population. EG explained that the register could be used to ensure that people providing services are aware of the specific needs of people with autism, encouraging them to engage with services and also to assess whether people with autism are accessing the same services including screening and other preventative health programmes. DH asked to clarify whether this register intends on including all people on the autism spectrum as it is a broad spectrum, including people with high functioning autism and Asperger's syndrome who may not necessarily require any adjustments

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	when attending appointments. AA noted that the register would only include those with a codes diagnosis of autism. EG explained that there is an issue with a large number of adults not having a diagnosis, and when they do get one there are little or no services to refer people to if they require support. EG also explained that young people with autism are particularly at risk of experiencing psychological problems, with higher rates of depression and anxiety in this population. PW asked that we are clear about the original reasons for establishing a register. The committee was aware of the 2016 Westminster Commission on Autism report. The committee agreed that this was to enable services to be aware of the specific needs of their patients who have autism and also to provide a denominator for any other indicators we may want to develop for this population. **Recommendation** DK summarised the discussions, recognising the potential benefits identifying this population could have on monitoring outcomes and uptake of health services, the committee agreed to recommend this indicator for inclusion on the menu. Tested indicator ***Rates of non-elective admissions for people with learning disabilities and or autism to mental health settings*** SR provided the background for this indicator. It was consulted on in February 2016, but was not brought to the committee as no feasibility assessment was possible at that stage. Therefore the outcome from consultation and feasibility testing is being presented today. SR went through the key themes from consultation. The need for a clear definition of learning disability was raised. Stakeholders suggested that there are often varied and complex reasons for why people may have a non-elective admission and a potential unintended consequence may be that people are discouraged to admit people in an emergency when it may be appropriate. SR presented the findings from the feasibility assessment for this indicator. The key issue related to small numbers as in the last year there were only 5,112 emergency admissions recorded for people with LD or autism into mental health services. This was not deemed to be an accurate figure however as the data used to construct the population estimates for the denominator has very poor national coverage (51.2%) with high levels of variation. The recommendation from NHS Digital was that this indicator is not feasible. DK asked whether improvements could be made in the collection and reporting of admission method to improve coverage. CD suggested this could be requested, but as it's not a mandatory field at the moment, submissions are varied. PW agreed

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	with the comments from stakeholders that there are often many reasons why people might be admitted and that this would be more suitable as a surveillance type indicator rather than an indication of quality. SH questioned what this indicator would tell a CCG as there are a number of factors that impact on why someone might be admitted to secondary care mental health services, both personal and local issues such as availability of beds. **Recommendation** DK summarised discussions, the committee recognised that this is an important area, but the current data isn't robust enough to support an indicator in this area. The committee therefore agreed to recommend that this indicator is not progressed.
11. Cancer screening	Consulted indicators ***GP6 – The proportion of women eligible for screening and aged 25 – 49 years at end of period reported whose notes record that an adequate cervical screening test has been performed in the previous 3.5 years*** ***GP7 – The proportion of women eligible for screening and aged 50 – 64 years at end of period reported whose notes record that an adequate cervical screening test has been performed in the last 5.5 years*** GF advised the committee that these indicators are based on the National Screening Committees (NSC) guidance concerning frequency of cervical screening amongst the 2 different ages groups. The indicators have not been piloted as there are current QOF indicators for cervical screening, albeit indicators that are not aligned with NSC guidance. These indicators would see a slight increase in the number of screening tests for the younger age group. GF went through the consultation comments, highlighting that stakeholders welcomed these indicators recognising that they were consistent with the NSC guidance. The committee reviewed the consultation comments and no issues were raised. **Recommendation** The committee agreed to recommend these indicators for inclusion on the NICE menu. Consulted indicator ***CCG14 – The proportion of eligible people aged 60-74 years whose records shows a bowel screening test has been performed within the last 2 years***

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	GF went through the consultation comments for this indicator. The committee discussed what part of the health service should be responsible for this indicator, and where there is low uptake, who would be accountable. AS advised that Public Health England commission the NHS to deliver this screening programme. AA suggested the issue is that if there is low uptake GPs get a null result as the patient hasn't taken part. GP's don't necessarily then follow this up as it is left to the screening programme to do. The committee discussed this issue and it was agreed that responsibility for increasing uptake for this should be across the health system. **Recommendation** The committee supported this indicator but asked that some further work was done to assess at what level this indicator would be best focused on either at CCG of other locality level. <u>Consulted indicator</u> ***CCG15 – The proportion of women aged 50-70 years whose record shows a breast screening test has been performed within the last 3 years*** GF went through the consultation comments. Stakeholders supported the indicator, suggesting that it could enable GPs to have a clearer role in maximizing uptake. Some concerns were raised about over diagnosis and consequent treatment. The committee agreed that the same issues with regards to the need for a whole system approach to supporting uptake in this indicator. **Recommendation** The committee supported this indicator but asked that some further work was done to assess at what level this indicator would be best focused on either at CCG of other locality level
Item 12 Antenatal and post-natal mental health	<u>Piloted indicator</u> ***GP11 – Postnatal enquiry*** ***The percentage of women who have given birth in the preceding 12 months who have had an enquiry about their mental health using the Whooley 2 depression questions and the GAD-2 between 4-10 weeks postpartum.*** SR went through the consultation comments. An indicator focused on assessing postnatal mental health in women was welcomed. There were some concerns raised about awareness, resource and capacity issues within GP practices. Some stakeholders questioned who should be carrying out the assessment and whether it should be other health professionals

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	rather than GPs. Some stakeholders felt that this was overly structured and that this check should happen at every appointment and that using screening tools could potentially have a negative impact on open personalised conversations. RFT went through the findings from piloting. The indicator had low levels of support from piloting practices. GPs fed back that the use of questionnaires was felt to be intrusive during a consultation. There were queries about how sensitive and specific the measures were for women in the postnatal period. There were some issues raised about whether this is duplication of work with that done by health visitors and midwives. JM went through the cost effectiveness assessment. The main assumption was that there would be QALY gains from improved access to mental health treatment due to the assessment being carried out compared to standard care. The indicator was deemed cost effective for incentivisation. TK suggested that the issues raised in piloting and consultation were not impassable objections. The concerns raised about the use of a structure tool to assess the mental well-being of the women could be overcome by not focusing on a specific validated tool and focus more on the concept that an assessment of the women's mental health has been made. If there is some repetition from different health care professionals asking similar questions, this is not necessarily a bad thing and if an issue was identified it would usually be up to the GP to take action. LP suggested that this is an important area and having some kind of measurement about whether an assessment has happened or not would be useful to highlight variation. The committee then discussed the timeframe for this indicator. It was noted that postnatal mental health issues can manifest itself anytime in the first 12 months. RC suggested that if the indicator is broadened to a 12 month period, women who are suffering mental health issues earlier on in the postnatal period could be missed. It was suggested that the time frame was extended to mirror the baby immunization timings. **Recommendation** DK summarised discussions. The committee agreed to recommend an indicator in this area for the NICE indicator menu. The committee recommended that the indicator was amended so that it did not focus on specific tools, but focused on whether an enquiry of their mental health has been carried out. The timeframe was set at 4-16 weeks. <u>Tested indicator</u> ***CCG12 - The proportion of pregnant women who were asked about their mental health at their first booking appointment***

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	SR went through the consultation comments for this indicator. There was support for the principle behind this indicator, but felt that the focus was too narrow and that these questions should be asked at every appointment. There were concerns raised about the skills and training for midwives to facilitate an open and meaningful conversation. SR advised the committee that NHS Digital's feasibility assessment found that this indicator was feasible. In December 2016 48,948 women had their first antenatal booking appointment and only 46.2% were asked about their emotional wellbeing. TK suggested that despite the indicator being limited in scope, as the data is showing that only 46.2% of women are asked about their emotional wellbeing and therefore it would seem worthwhile measuring. PW and SH both made the point that if this is feasible then it should be measured and CCG's would use the information. **Recommendation** The committee agreed to recommend this indicator for inclusion on the NICE indicator menu. Tested indicator ***CCG13: The proportion of women referred for psychological interventions in pregnancy or the postnatal period who start treatment within 6 weeks of referral.*** SR went through the consultation comments for this indicator. There was general support for this indicator, but some practical issues were flagged. There was need for greater awareness of the availability of IAPT service to support women during and after pregnancy. At the same time it was felt that there wasn't sufficient capacity available within IAPT services to support this population and that further investment was needed. One stakeholder felt that 6 weeks wait for specialist treatment is too long for this population considering the extra vulnerability in the postnatal period. The committee were advised that NHS Digital have been unable to conduct a feasibility assessment for this indicators as it would require data linkage between the Mental Health Dataset and the Maternity Services Dataset. This has not yet happened. The work linked to this indicator being led by the National Perinatal Epidemiology Unit is still ongoing. The committee will be advised about the progress of this work at the next committee. **Recommendation**

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	The NICE team to work with NHS Digital colleagues to monitor progress in linking of these datasets and update the committee at future meetings.
Item 13. Acute Heart Failure	Tested indicator ***CCG1 – The proportion of people presenting to hospital with new suspected acute heart failure who have a single measurement of natriuretic peptide*** GF went through the consultation comments. Stakeholder supported this indicator as a vital investigation for appropriate diagnosis. The availability of the test was highlighted as a potential issue, the committee heard that the test is not available in all acute care settings. CD advised the committee that NHS Digital intended to conduct a feasibility assessment of all the acute heart failure indicators using data from the National Heart Failure Audit led by the National Institute for Cardiovascular Outcomes Research (NICOR). However, CD informed the committee that this has not yet been possible as there have been delays in NICOR releasing the data to NHS Digital. Therefore it has not been possible to conduct the feasibility assessment yet. The committee agreed that the indicator was an important part of the diagnostic process. However, due to the lack of feasibility assessment, the committee agreed that this indicator would need to come back to a future meeting when the assessment has been completed. **Recommendation** Indicator to be brought back to the committee when a feasibility assessment has been carried out. Tested indicator ***CCG2 – The proportion of adults admitted to hospital with new suspected acute heart failure and raised natriuretic peptide levels who have a transthoracic doppler 2D echocardiogram*** GF went through the consultation comments. Stakeholders supported the indicator as an important part of the diagnostic process. The increase in testing was seen as a potential issue as it would put more pressure on pressured cardiac physiology departments. A timeframe of 'within 48 hours of admission' was suggested to ensure that access was timely and in line with the NICE guidance.

Agenda item	Discussions
	The committee again agreed that this would need to be looked at again when a feasibility assessment had been carried out. DK did question the extent to which indicators CCG1 and CCG2 would lead to changes in practice as he has seen results from the national audit that show 90% of people admitted for suspected acute heart failure have had an ECG. Recommendation Indicator to be brought back to the committee when a feasibility assessment has been carried out. Tested indicator ***CCG3 – The proportion of adults admitted to hospital with acute heart failure who have input within 24 hours of admission from a dedicated specialist heart failure team*** GF went through the consultation comments. Some stakeholders supported this indicator stating that it was a much needed part of the clinical management process for these patients. Other stakeholders recognised the importance of these team, but highlighted that there could be resource issues as not all sites would have access to a dedicated team in this timescale. The ability to collate accurate audit data for this indicator was also highlighted as a potential issue. The committee discussed the timescale with a suggestion being made that this should be within 72 hours to take into account that access to dedicated teams 7 days a week may not be feasible. This was not supported however by the majority of the committee. SH highlighted that the definition of dedicated specialist heart failure team would need to be clarified as small District General Hospitals, would be unlikely to have access to such as team. Recommendation Indicator to be brought back to the committee when a feasibility assessment has been carried out. Tested indicator ***CCG4 – The proportion of adults with acute heart failure who have a follow up clinical assessment by a member of the community or hospital based specialist heart failure team within 2 weeks of hospital discharge***

Agenda item	Discussions
	GF went through the consultation comments. Stakeholders supported this indicator as being an important process in reducing hospital readmission. Access to these teams in all community settings was flagged as an implementation issue for this indicator. The committee agreed that this is an important indicator, but would await the feasibility assessment. <u>Recommendation</u> Indicator to be brought back to the committee when a feasibility assessment has been carried out.
Item 14. Review of decision	BB went through the day's business and confirmed the decision made by the committee
Close of committee Meeting (day one)	DK thanked all in attendance and closed day one of the meeting.