# National Institute for Health and Care Excellence

### Indicator Advisory Committee meeting minutes

**Date:** 7 September 2021

**Location:** Virtual via Zoom

**Attendees:**

**Indicator Advisory Committee members:**

Ronny Cheung (RC) [chair], Andrew Black (AB) [vice-chair], Tessa Lewis (TL), Adrian Barker (ABa), Allison Streetly (AS), Chloe Evans (CE), Linn Phipps (LP), Liz Cross (LC), Michael Bainbridge (MB), Tim Cooper (TC), Victoria Welsh (VW), Waqas Tahir (WT), Mary Weatherstone (MW), Elena Garralda (EG)

**NICE attendees:**

Charlotte Fairclough (CF), Craig Grime (CDG), Rick Keen (RK), Mark Minchin (MM), Theresa Jennison (TJ)

**National Collaborating Centre for Indicators Development (NCCID):**

Andrea Brown (ABr), Paula Whitty (PW), Paul Collingwood (PC), Richard Thomson (RT), Jackie Gray (JG)

**Topic Experts invited to attend the committee:**

Dermot Neely (DN) – Consultant in Clinical Biochemistry and Metabolic Medicine

Peter Green (PG) – Clinical Lead for CVDPrevent audit and Chair of Heart UK

**Apologies:**

Christopher Gale, Dominic Horne, Kate Francis, Rachel Brown, Nigel Beasley

**Quoracy:** the meeting was quorate.

**Item 1 - Outline of the meeting**

RC welcomed the attendees and the indicator advisory committee (IAC) members introduced themselves. RC noted that DN and PG would be joining the committee as topic experts for the lipid management agenda item.

**Item 2 - NICE advisory body declarations of interest**

RC asked committee members to declare all new interests, that is those not already included in the register of declared interests NICE has on file and all interests related to items under discussion during the meeting. The following interests were declared:

* MM noted that he is part of the CVDPrevent Audit Steering Group which includes lipid modification, and of which invited topic expert Peter Green is the Chair.
* TC noted that he has stepped down as Director from the Quality Review Service and has been appointed as the Chair of the West Midlands Imaging Network Board.
* VW noted that her research funded by the NIHR is ongoing and that she has received new research funding from the Foundation for Research in Rheumatology.
* LP noted that her role as lay member for the Department of Health and Social Care Independent Reconfiguration Panel has now ended.

**Item 3 - Review of minutes and actions from June 2021 meeting**

TJ informed the committee that all of actions from the last indicator meeting in June 2021 had been progressed.

PW highlighted a matter arising on Item 6. It was clarified that revised assessment forms on indicators IAP00127 and IAP00325 may return to the committee pending further discussions with NHS Digital on their data source. It was noted that NICE will delay the update to the indicator menu on their website until this has taken place.

The June 2021 minutes were approved as an accurate record.

**IND2020-93 (Developmental dislocation of the hip screening)**

CDG updated the committee on an action from the June 2021 committee meeting regarding IND2020-93. The committee had previously questioned the estimated numbers for the denominator. CDG confirmed that following discussions with PHE, corrected figures were now available that showed the indicator was suitable for use at CCG level. However, it was noted that the indicator now required further amendment as data is now being collected against: *The proportion of babies with a screen positive newborn hip result who attend for ultrasound scan of the hips within the designated timescale*.

The committee queried whether the indicator wording should include ‘and/or national hip risk factors’. CDG noted that the definition of a ‘screen positive newborn hip result’ includes babies with national hip risk factors.

**ACTION: NICE team to circulate documentation and confirm whether further amendment is needed with the committee via email before progressing to the NICE menu.**

**NICE and Indicator programme update**

MM provided a general update on aspects of the indicator programme and NICE that were not being covered in today’s meeting.

**Items 4a – 4e – Development of indicators 21/22**

MM updated the committee on the development work on draft indicators for vaccinations and immunisations, lipid management, chronic kidney disease, epilepsy and SMI. The committee were informed of their objectives for the day for each of these topics.

**Vaccinations and immunisations**

CF presented a summary of the consultation for three draft indicators for vaccinations and immunisations. It was noted that no new consultation was held for these indicators given the similarities to previous consultations, but comments were sought from the British Medical Association and the RCGP.

The committee discussed to what extent it is asked to advise on thresholds and their achievability. MM noted that while the committee has had an informal role in the past in providing advice on thresholds, it no longer does. The committee suggested that it could offer its expertise to the necessary professional bodies in the way of providing a steer on this threshold.

**ACTION: NICE team to speak to NHS England about providing informal advice on payment thresholds.**

**IND2021-111:** *The percentage of babies who reached 6 months old in the preceding 12 months, who have received 2 doses of rotavirus vaccine before the age of 6 months.*

The committee was asked to consider the following:

* Keep the indicator wording in line with other indicators on the NICE menu (measurement before the age of 6 months) but ensure the specification details measurement before 24 weeks old.
* The indicator should progress to the NICE menu.

The committee agreed that the indicator should measure receipt by 6 months given that the rotavirus vaccine can only be given up to 24 weeks of age.

The committee discussed whether the indicator needs to clarify that ‘6 months’ gives flexibility for data entry, as opposed to when they are given the vaccines. It was noted that payment is only qualified if the vaccine is given before 24 weeks.

**Action: Progress to the NICE menu.**

**IND2021-112:** *The percentage of babies who reached 8 months old in the preceding 12 months, who have received 2 doses of a Meningococcal B vaccine before the age of 8 months*

The committee was asked to consider the following:

* The indicator should progress to the NICE menu.

The committee noted that most babies will come to receive this vaccine at 4 months old. It was highlighted that some clinics can experience delays with babies coming from abroad, but they can catch-up. Committee members noted that the papers did not include a SNOMED code for ‘did not attend MenB vaccine’ but there is a code for patient decline which could be used.

**Action: Progress to the NICE menu with clarification of the recommended schedule in the guidance documentation.**

**IND2021-113:** *The percentage of children who reached 18 months old in the previous 12 months, who have received 2 primary doses and 1 booster dose of a meningococcal B vaccine before the age of 18 months.*

The committee was asked to consider the following:

* The indicator should progress to the NICE menu.

The committee agreed that this indicator should progress to the NICE menu.

**Action: Indicator to progress to the NICE menu.**

**Lipid management**

The committee welcomed DN to the discussion. AB asked DN to declare any interests relevant to the topic:

* DN noted that he has received several honoraria from industry bodies relating to lipid management including Novartis, Pfizer and the Primary Care Cardiovascular Society in the last five years.
* DN noted that he has received educational video fees from AMGEN and the British Journal of Cardiology.
* DN noted that is a Trustee of Heart UK and the co-author of the AAC Lipid Management Pathway.

The committee noted PG’s apologies for the meeting.

RT informed the committee of the methodology for identifying potential areas for new general practice indicators regarding lipid management. Four areas were identified for potential indicator development:

* Risk assessment
* Primary prevention
* Secondary prevention
* Follow up/monitoring

DN highlighted difficulties in developing performance measures using a percentage reduction target for non-HDL cholesterol in current clinical IT systems. He queried whether previous concerns around the use of an absolute value target are mitigated by recent NICE technology appraisals for lipid management therapy that use absolute values to help inform eligibility. He noted new evidence that reducing non-HDL below the 40% target does not increase risks. He noted however that there may be increased risks of haemorrhagic stroke in some patients who achieve very low LDL cholesterol levels.

**Proposed area for indicator development 1 (Risk assessment):** *QRISK assessment within a defined period for all people with type 2 diabetes.*

The committee noted that existing NICE indicator NM160 focuses on cardiovascular risk assessment within the last 3 years for people aged 25-84 years with a diagnosis of type 2 diabetes, without moderate or severe frailty and not currently treated with a statin.

DN noted that the AAC Pathway recommends using QRISK3 as opposed to QRISK2 currently recommended by NICE CG181. The committee noted that QRISK3 would not lead to a substantial difference in the numbers of people identified as at risk compared to QRISK2. The committee highlighted that repeated risk assessment for all people with type 2 diabetes would enable a personalised care approach for people not taking statins. The committee highlighted that the risk assessment should be conducted in a way that can support lifestyle modifications and decision making about lipid modification therapy.

The committee queried whether the 3-year timeframe could be lowered.

**Action: Progress for further exploration.**

PW checked with the committee whether there were any other risk assessment areas that should be explored for potential indicator development, but none were identified from the discussion.

**Proposed area for indicator development 2 (Primary prevention):** *Lifestyle advice and intervention for those with a newly identified 10-year CVD risk of 10% or more.*

The committee was asked to consider the following:

* Indicator NM122 “*The percentage of patients with coronary heart disease, stroke or transient ischemic attack, diabetes and/or chronic obstructive pulmonary disease who have influenza immunisation in the preceding 1 August and 31 March*” could be adapted.
* Lifestyle interventions (where appropriate) including referral to weight management, support or treatment for smoking cessation, brief alcohol intervention, brief exercise intervention.

The committee agreed with this area and noted that provision of advice and support with lifestyle changes can be undertaken by wider primary care and PCN staff.

**Action: Progress for further exploration.**

**Proposed area for indicator development 3 (Primary prevention):** *Use of a patient decision aid.*

The committee was asked to consider the following:

* NICE has produced a patient decision aid (PDA) to accompany NICE guidelines CG181
* Exploring the development of such an indicator was recommended by the indicators advisory committee patient choice sub-group.

The committee noted that a PDA does not necessarily indicate a quality discussion with the patient.

The committee highlighted the usefulness of the NICE CG181 PDA, including for clinicians to help with summarising the evidence.

The committee noted the opportunity to use this as a pilot project in the development of shared decision-making indicators for other conditions.

**Action: Progress for further exploration.**

**Proposed area for indicator development 4 (Primary prevention):** *Statin use for people who have a 10% or greater 10-year risk of CVD.*

The committee highlighted potential issues of using drug prescriptions in the construction of indicators. PW noted that recent indicator development using CPRD data on antidepressants provided some proof of concept of using drug prescriptions in indicator construction.

**Action: Progress for further exploration. NICE team to consult with NHS Digital on the use of drug prescriptions in indicator construction.**

**Proposed area for indicator development 5 (Primary prevention):** *Statin use for people with CKD.*

RT highlighted that this area is also highlighted for potential indicator development in the subsequent CKD paper. No issues or concerns were raised.

**Action: Progress for further exploration.**

**Proposed area for indicator development 6 (Secondary prevention):** *Statin use for people with CVD.*

DN noted that there are other ways to achieve the effect of high-intensity statin therapy beyond atorvastatin at 80mg and advised that any potential indicators should not penalise the use of beneficial alternatives.

The committee noted concerns around overtreatment particularly if people are elderly or frail. It was agreed that further exploration around maximum doses for these populations would be useful.

**Action: Progress for further exploration.**

**Proposed area for indicator development 7 (Follow up/monitoring):** *Measurement of lipids and liver transaminases 3 or 12 months after new treatment with high intensity statins.*

The committee agreed that this is part of good prescribing. The committee highlighted that measuring at 3 months would be very useful, but the 12-month timeframe could be more complicated as it could lead to unnecessary repeat tests.

**Action: Progress for further exploration**

**Proposed area for indicator development 8 (Follow up/monitoring):** *Reduction in non-HDL cholesterol 3 months after starting treatment with high intensity statins for primary or secondary prevention.*

Noting previously discussed difficulties in using a percentage reduction for non-HDL cholesterol, the committee was asked to consider whether there is a proxy construction that is more suitable for data collection and extraction. DN again noted published NICE technology appraisals that use an absolute value to determine eligibility.

The committee agreed that the use of an absolute value target could be a pragmatic approach as primary care IT systems are unable to calculate percentage reductions within their algorithms. The committee also noted that other international cardiology and diabetes guidance use absolute value targets. AB queried whether it would be feasible to develop a hybrid indicator that used percentage reduction if available and absolute value if not. RC reiterated that the committee should not deviate from NICE guidance but acknowledged that published technology appraisals may support exploration of an indicator using absolute value targets.

**Action: Progress for further exploration.**

**Chronic kidney disease (CKD)**

CF informed the committee that NICE have recently published a new guideline on CKD (NICE NG203) this new guideline updates and replaces CG182 (chronic kidney disease in adults), CG157 (management of hyperphosphatemia) and NG8 (management of anaemia).

JG informed the committee of the methodology for identifying potential areas for new general practice indicators regarding CKD. Three potential areas were identified for indicator development:

* Early identification
* Diagnosis and management
* Management of complications

The committee was asked to consider the following queries:

* What are the priorities for indicator development in these areas?
* Are there any specific proposals to explore further?
* Where could stratification add most value?

**Early identification**

The committee highlighted that measures on renal function for patients taking non-steroidal medications could be useful. It was noted that the quantity of such medications (NSAIDs and other nephrotoxic drugs) would need to be specified to assess workload of any indicators.

The committee highlighted the importance of encouraging preventative measures.

JG highlighted the National CKD Audit which noted that a third of patients were not being coded who had confirmed CKD from a blood test. The committee suggested that there need to be improvements in coding and diagnostics for earlier identification and cost effectiveness. It was suggested that the current QOF CKD registers have become more inaccurate with time due to less emphasis on the stratification of patients. More accurate coding of CKD staging would help to identify patients for appropriate treatment. The committee highlighted the new recommendation on use of SGLT2 inhibitors in NICE NG203.

The committee noted that there could be a focus on monitoring patients with Acute Kidney Injury (AKI) and their potential to develop to CKD. PW highlighted that previously piloted indicators on the progression of AKI to CKD were not progressed to the NICE menu. It was noted that it could be re-explored given that this is a focus on CKD.

**ACTION: Progress the areas of monitoring renal function in people taking nephrotoxic drugs or following an episode of AKI for further exploration.**

**Diagnosis and management**

The committee noted the importance of coding in that, if patients are not coded, the condition is not recognised which can lead to a greater risk of admissions. It was suggested that two separate indicators could be constructed with one coded for G3a – G5 patients and one coded for faster progression, higher risk patients. It was highlighted that this would account for the greater pharmaceutical complications of the high-risk group. The committee noted the importance of early diagnosis of CKD.

The committee discussed the potential for an indicator quantifying the percentage of patients with CKD who meet NICE criteria for a renal ultrasound or specialist referral. Concerns were raised that the referral numbers maybe be too small to create a robust indicator for measurement of care within a general practice setting.

The committee noted that there needs to be an indicator surrounding testing for proteinuria which is a critical area of CKD management. It was noted that such an area is supported in the NICE CKD guidance and is proven to lower mortality rates. JG highlighted INLIQ data which showed that over time urine testing for people with CKD had reduced, reflecting changes to live QOF indicators. The committee highlighted recommendations on the use of SGLT2 inhibitors in people with CKD and type 2 diabetes and ACR greater than 30 mg/mmol.

The committee noted previous retired CKD indicators from the QOF, that may be useful for the development of this indicator area. PW confirmed that there were CKD indicators relating to renal function and blood pressure that could be useful.

**ACTION: Progress for further exploration. NEQOS to review CKD indicators retired from the QOF for potential inclusion on the NICE menu.

Management of complications**

The committee discussed whether the various proposals related to complications would be suitable as indicators for inclusion in the QOF as some patients would be being managed in secondary care.

The committee agreed that indicators on management of complications should be explored further, but that some may be more suitable at network level.

**ACTION: Progress for further exploration.**

**Epilepsy**RT informed the committee of the methodology for the development of four potential general practice epilepsy indicators, focusing on annual review. The committee were asked to consider whether NICE should explore any of these indicators further.

The committee highlighted the importance that these indicators should consider new upcoming epilepsy guidance, due in 2022. MM noted that the NICE team will be engaging with the guidelines team after the first draft of the new guidance is published in September 2021.

**Proposed indicator 1 – Review of all adults:** *The percentage of adults receiving drug treatment for epilepsy who had a structured review in the preceding 12 months.*

The committee was asked to consider the following:

* This indicator appears most likely to be feasible at practice level due to the relatively high population included in the specification.

The committee noted that reviewing patients is important for reducing seizure frequency.

The committee discussed as to whether primary or secondary care would carry out the review and the need for reporting and communication between the two areas. It was highlighted that this is already accommodated within other QOF areas such as rheumatoid arthritis. It was noted that from a patient perspective, the important aspect is whether or not a review occurs, not where it is carried out.

**ACTION: Progress for further exploration. Clarify how reviews taking place within secondary care would be counted.**

The committee agreed to discuss the next three indicators together.

**Proposed indicator 2 – Review for adults with learning disabilities**: *The percentage of adults receiving drug treatment for epilepsy with learning disabilities who had a structured review in the preceding 12 months.*

The committee was asked to consider the following:

* This indicator appears unlikely to be viable at GP practice level due to likely small numbers of patients and may be more suitable at primary care network level.

**Proposed indicator 3 – Review for adults with a mental health condition:** *The percentage of adults receiving drug treatment for epilepsy with a mental health condition who had a structured review in the preceding 12 months.*

The committee was asked to consider the following:

* This indicator may have relatively low numbers at practice level – this will need addressing during piloting to determine if it is best measured at practice or primary care network level.
* This indicator may require additional diagnostic codes to capture the full population. This can be developed and tested as part of any indicator piloting.

**Proposed indicator 4 – Review for older people:** *The percentage of adults 65 and over receiving drug treatment for epilepsy who had a structured review in the preceding 12 months.*

The committee was asked to consider the following:

* This indicator may also have relatively low numbers at practice level – this will need addressing during piloting to determine if it is best measured at practice or primary care network level.

The committee advised that, during development, it should be made clear why these sub-groups were chosen and whether the guidance makes specific reference to these sub-groups.

RT clarified that such groups are both hard-to-reach and are at a higher risk of epilepsy.

The committee noted that even if the denominator size is too small for potential inclusion in the QOF, the indicators could be progressed at network level.

**ACTION: Progress for further exploration.**

**Additional indicators**

The committee discussed additional epilepsy indicators that could be explored.

The committee highlighted the importance of examining seizure frequency and options for people with treatment resistant epilepsy.

The committee discussed outcomes surrounding emergency treatment and carer support. It was noted that these should be covered by the annual review.

The committee noted ongoing initiatives to improve safe prescribing of sodium valproate. It was agreed that this should be highlighted in supporting documentation for any resulting annual review indicators.

**ACTION: Additional epilepsy indicators to be revisited following the publication of the new guideline.**

**Serious Mental Illness (SMI) composite indicator**

*The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure, lipid profile, blood glucose (or HbA1c), BMI, alcohol consumption and smoking status in the preceding 12 months.*

CDG informed the committee of a proposal from NHS England to consider the suitability of this composite indicator for inclusion in the QOF. It was noted that the NICE menu contains separate indicators for all six elements and so additional consultation had not been undertaken. It was also noted that the QOF also includes the six components, however the recording of smoking status for people with SMI (SMOK002) which includes multiple other long-term conditions.

The committee was asked to consider the following:

* Three of the six NICE indicators use a time frame of 15 months, as opposed to the usual 12-month timeframe currently used in the QOF.
* Misalignment between NICE guidance and QOF MH011 which promotes an annual lipid profile in patients at higher risk of CVD and every 24 months for people without higher risk factors.
* Potential issues in terms of transparency and construction.
* Progressing to the NICE menu as suitable for inclusion in the QOF.

The committee agreed that the composite indicator should use a 12-month timeframe, despite three existing indicators using a 15-month timeframe.

The committee agreed that the lipid monitoring component should be in line with NICE guidance and existing NICE indicator NM129: annual monitoring for all patients with SMI.

The committee asked whether the presence of a single ‘personalised care adjustment’ would remove a patient from the denominator. It was noted that if constructed this way there would be high levels of personalised care adjustments and little incentive to complete the remaining health checks. The committee stressed the importance of using a composite indicator alongside the individual indicators for each component to avoid the indicator becoming a ‘black box’. CDG clarified that construction would need to be investigated with NHS Digital.

The committee noted that to be categorised as suitable for inclusion in the QOF, the QOF would require the addition of a separate indicator that specifically monitored the recording of smoking status for people with SMI (based on NICE NM124).

**ACTION: NICE team to consult with NHS Digital on the likely construction of the business rules and bring back to the committee.**

**Item 5 – Assuring external indicators – National Library of quality indicators**

PC presented the methodology which had been adopted for review of eight indicators due for renewal. The process was based on the NICE indicator process guide. The committee approved the renewal of the eight indicators for which no issues were identified by NCCID.

PC presented the assessment of one indicator where the input of the committee was requested.

IAP00139 – the committee agreed that this indicator should be renewed.

**Item 6 - Review of decisions**

TJ confirmed to the chair that details of the business and all recorded decisions and actions discussed had been noted.

**AOB**

LP noted the importance of future indicators focused on preventative measures. RC highlighted the opportunity to explore such measures in light of the NICE strategy and ICS updates.

RC thanked the committee and staff from NICE and NCCID for their input.

The NICE team and the committee gave a farewell to AS who will be moving to a new post at NHS England / Improvement in October 2021.

**Close of meeting**