# National Institute for Health and Care Excellence

### Draft - Indicator Advisory Committee meeting minutes

**Date:** 7 Nov 2022

**Location:** Virtual via Zoom

**Attendees:**

**Indicator Advisory Committee members:**

Ronny Cheung (RC) [chair], Andrew Black (AB) [vice-chair], Adrian Barker (ABa), Chloe Evans (CE), Linn Phipps (LP), Liz Cross (LC), Michael Bainbridge (MB), Victoria Welsh (VW), Waqas Tahir (WT), Mary Weatherstone (MW), Elena Garralda (EG), Rachel Brown (RB), Kate Francis (KF), Ben Anderson (BA), Paula Parvulescu (PP), Martin Vernon (MV), Tessa Lewis (TL), Dominic Horne (DH), Chris Gale (CG)

**NICE attendees:**

Craig Grime (CDG), Rick Keen (RK) [minutes], Mark Minchin (MM), Charlotte Fairclough (CF), Nicola Greenway (NG), Eileen Taylor (ET), Rosalee Mason (RM) [host]

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

Andrea Brown (ABr), Kate Thurland (KT)

**NHS Digital:**

Laura Corbett (LC)

**NICE observers:**

Daniel Smithson, Craig Davidson, Philip Ranson

**Apologies:**

Chris Wilkinson, Mieke van Hemelrijck, Raju Reddy

**Quoracy:** the meeting was quorate.

**Item 1 - Outline of the meeting**

RC welcomed the attendees and the indicator advisory committee (IAC) members introduced themselves.

**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 circulated in today’s papers) and all interests related to items under discussion during the meeting:

Waqas Tahir – Received speaker fees from Amarin and Bayer Plc, has joined two clinical advisory groups for NHS England - Primary Care Diabetes Recovery and Primary Care Diabetes Europe.

Ronny Cheung – Taken an honorary role of Officer for Health Services at the Royal College of Paediatrics and Child Health

Liz Cross – Working with Abbot Diagnostics on health check screenings for hard-to-reach populations.

**Item 3 - Review of minutes and actions from June 2022 meeting**

MM informed the committee that all actions from the last committee meeting in June 2022 had been progressed or were included in today’s agenda.

The June 2022 minutes were approved by the committee as an accurate record.

**Item 4 – Lipid modification: secondary prevention**

MM presented the background on how the draft lipid modification indicator had been developed. The committee was reminded of the challenges of using the existing NICE guideline (CG181) specifically the guidelines focus on the initiation of statins and advice from NHS Digital that the current national system used to undertake data extractions for QOF (GPES) is unable to calculate the 40 percent reduction in non-HDL cholesterol recommended by the NICE CG181 at 3 months of treatment.

MM explained how in the absence of suitable NICE guideline extensive consideration was given to three alternative options; using non-NICE guidelines, estimating how a 40 percent reduction in non-HDL may translate in a treatment level indicator and finally if an indicator for population level improvements could be developed using current practice data and NICE non-guideline products. MM noted the challenges associated with each of the approaches and suggested that each approach required increasing pragmatism.

MM noted the issues associated with using non-NICE guidance, highlighting how the development methods used often vary from the approach used by NICE. MM also noted how translating what a 40 percent reduction in non-HDL may look like as a treatment target was also problematic highlighting that CG181 referred to 40 percent reduction 3 months after starting treatment with high intensity statins, it does not provide advice on longer term treatment.

MM described that the final option had been used as a pragmatic approach to derive an absolute target indicator that could be used until NICE guidance incorporating clinical and cost effectiveness evidence was available. The draft indicator that NICE consulted on was based on both published NICE HTA guidance and current national practice data taken from CVDPREVENT and was developed with input from IAC and NICE CVD topic suite members.

The committee was aware that in August 2022 NICE published an indicator suitable for use in the 2023/24 QOF that covered the same group of patients as this indicator (NICE NM212). NICE NM212 can be used to incentivise the use of lipid lowering therapies in patients with established CVD.

MM provided the committee with an update on when NICE will update CG181 to specifically address the issue of treatment levels for secondary prevention. MM stated that it had just been confirmed that a final NICE guideline covering this aspect of care was expected in September 2023 with a draft guideline expected in June 2023. Finally, MM reminded the committee how this guideline publication schedule would align with the annual QOF cycle, noting the high potential for misalignment between a NICE indicator that subject to QOF contract negotiations may go live in April 2023 and the NICE guideline where draft guidance was expected in June 2023 and final guidance in September 2023.

IND 2022-133:

*The percentage of patients with CVD in whom the last recorded non-HDL cholesterol (measured in the preceding 12 months) is less than 3.3 mmol/L.*

CF gave an overview of the rationale and stakeholder consultation feedback for this indicator. It was highlighted that the draft indicator aims to drive population level improvements in secondary prevention of CVD reducing morbidity and mortality.

CF highlighted that whilst there was clear support for an indicator that used an absolute treatment target, there was a wide range of views from stakeholders on the level that should be used. CF further noted that whilst there was near universal agreement that the non-HDL figure of 3.3 mmol/L used in the draft indicator was not appropriate suggestions for alternatives ranged from an LDL-C of less than 1.4mmol/L (equivalent to non-HDL of about 2.1 mmol/L) to non-HDL of 4.0 mmol/L.

In response to consultation feedback, the committee was asked to consider the following options:

* Should the indicator progress to publication on the NICE menu?
* Should a revised version progress to publication on the NICE menu?
* Should NICE pause work on this indicator until the updated NICE guideline on CVD is published in 2023?

Aware of the polarized views on what the treatment level should be, and conscious of the updated NICE guidance becoming available in 2023 the committee discussed pausing development of the indicator until the publication of the updated NICE CVD guideline. The committee noted a pause would remove future misalignment between NICE products and potential confusion within the care system.

The committee noted that the pragmatic approach used to develop the draft indicator was undertaken at a time when it was unknown when an updated NICE guideline would be available, now it was confirmed that draft guidance was expected in June 2023 the pragmatic approach and the associated risk of having multiple treatments targets being used needed to be reconsidered.

It was noted by CG that other international guideline producers publish indicators alongside their guideline. MM noted that this collaborative approach publishing indicators alongside guidance would align with NICE’s strategy. It was suggested that committee volunteers could be sought to help with this work. The NICE team clarified that it could work closely with the guideline developers to receive early knowledge of its work in this area and bring this to the June 2023 IAC meeting. The committee suggested that stakeholder comments from this consultation be shared with the guideline development group.

Members suggested that the NICE guideline update should include questions on non-HDL targets for patients with familial hypercholesterolaemia and chronic kidney disease to inform potential future indicator development.

The committee concluded that work on IND 2022-133 should pause until the updated NICE guideline is available. The committee recommended that NICE publish the final indicators alongside the NICE guideline.

**ACTION:** **NICE team to pause work on IND 2022-133 until the draft NICE guideline recommendations on CVD are available and work to publish the indicators in conjunction with the guideline.**

**Item 5 – Atrial fibrillation: anticoagulation**

CDG presented the background on one indicator on atrial fibrillation for discussion by the committee for potential publication. It was noted that the indicator had been consulted on with stakeholders. It was suggested that this indicator could be progressed to the NICE menu as a replacement or additional indicator to NICE NM82.

IND 2022-131:

*Percentage of patients with atrial fibrillation and a last recorded CHA2DS2-VASc score of 2 or more who are currently prescribed a direct-acting oral anticoagulant (DOAC), or where a DOAC is declined or clinically unsuitable, a Vitamin K antagonist*

CDG gave an overview of the stakeholder consultation feedback for this indicator. It was noted that anticoagulation in patients with AF can help prevent stroke. The committee heard that DOACs are more effective than Vitamin K antagonists for a range of outcomes and should be used as a first line treatment for people with an increased risk of stroke who meet licensing indications. The committee heard that the new indicator would require either a DOAC prescription or DOAC PCA for all patients, irrespective of Vitamin K antagonist provision.

In response to consultation feedback, the committee was asked to consider the following:

* Whether the indicator should progress to the NICE menu, either in addition to the existing indicator (NM82) or as a replacement

The committee noted that the potential benefits of switching to DOACs should still be discussed with stable AF patients. It was highlighted that some patients may not know about alternatives to Vitamin K antagonists, and this indicator is to ensure that the conversation is happening to promote DOAC use. Concerns were raised over inappropriate switching of anticoagulant in some patients.

Members highlighted that this indicator would help encourage more AF patients into more optimal care as defined by NICE guidance. It was noted that care needs to be given in how the switch from Vitamin K antagonists to DOACs is achieved. It was highlighted that this could be completed by a pharmacist as well as a GP but that this may be limited by staffing capacity in primary care.

The committee queried whether this indicator would include conditions in which DOACs are not indicated such as antiphospholipid syndrome and valvular AF. The NICE team agreed to verify exclusion of antiphospholipid syndrome and valvular AF in the indicator business rules. It was suggested that AF patients not eligible for DOACs should be dealt with via exclusion rather than PCA rules. It was noted that this may present difficulties that could be solved by changing the indicator denominator to ‘patients who are eligible for a DOAC’. It was highlighted that this would remove the need for a threshold but would require further explanation of the treatment pathway. It was suggested that there could be two indicators; one focussed on total anticoagulation, and one specifically focused on DOAC use.

The committee concluded that following clarification of the business rules and eligibility issues, and chair and vice-chair approval IND 2022-131 should progress to publication.

**ACTION: Following clarification around the business rules and eligibility for DOACs and subsequent signoff by the committee chair and vice-chair NICE team to progress IND 2022-131 for publication on the NICE menu.**

**Item 6 – Mental health: physical health checks**

ET presented the background on one indicator on mental health checks for people with severe mental illness (SMI) for discussion by the committee for potential publication. It was noted that the indicator had been consulted on with stakeholders.

IND 2022-127:

*Percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who, in the preceding 12 months, received all six elements of physical health checks for people with severe mental illness.*

ET gave an overview of the stakeholder consultation feedback for this indicator. It was highlighted that annual checks can identify and address modifiable risk factors linked to premature death. The committee heard that people with SMI are at a greater risk of poor physical health and die on average 15 to 20 years earlier than the general population. It was highlighted that major causes of death in people with SMI include CVD, respiratory disease, diabetes, and hypertension.

The committee was aware that this was an amended version of a composite / bundled indicator originally considered by the committee in September 2021. This was not taken forward by the committee at that time as a personalised care adjustment (PCA) against any of the 6 checks would have removed the patient entirely from the denominator.

In response to consultation feedback, the committee was asked to consider the following:

* Should the indicator progress to the NICE menu as suitable for inclusion in the QOF?

The committee noted that this indicator would present more robust incentivisation of mental health checks. Concerns were raised that having an aggregate measure on SMI conditions risks losing the detail in which individual checks are completed and which are not for this population. CDG highlighted that even though there is high achievement in the individual condition indicators, their overall PCA performance is low. LC highlighted that as currently set out in the business rules the health checks can be conducted at any point in a 12-month period.

Members noted difficulties in engaging these patients particularly in practices in deprived areas; this group of people is often underserved. It was noted that such practices may be unfairly miss out on financial incentives for not achieving these indicators.

The committee considered stakeholder comments about how there is a measurement but no indication of what to do next. Comments surrounding the omission of other conditions such as borderline personality disorder were noted as an area of concern. It was highlighted that this indicator has a particular focus on conditions that promote use of psychotropic medications which may not fit all mental health conditions.

Concerns were raised that the indicator definition excludes people in remission as this population may still experience inequalities and are still at risk of long-term relapse. CDG noted that this is a carryover attribute from the current QOF indicators. The committee heard that adding people who are in remission and on psychotropic medications but not currently on the SMI register creates new indicators in the QOF that could not be compared to this indicator. LC confirmed that via this indicator patients in remission would remain on the SMI register but would come out of the denominator.

It was suggested that this indicator should progress as a supplement to existing indicators, rather than as a replacement. It was noted that there may be greater achievement of all health checks by grouping them as opposed to keeping them as individual indicators. The NICE team highlighted that the individual SMI indicators would be needed to obtain data on provision of individual health checks. It was agreed that this would be highlighted in the indicator documentation at publication.

The committee concluded that IND2022-127 should progress to publication.

**ACTION: NICE team to progress IND 2022-127 for publication on the NICE menu with amendment to the rationale to note that existing SMI indicators remain in operation to pull data on individual health checks.**

**Item 7 – Blood pressure in people with chronic kidney disease (CKD)**

CF presented the background on two indicators on blood pressure in people with CKD for discussion by the committee for potential publication. It was noted that the indicator had been consulted on with stakeholders.

IND 2022-136:

*The percentage of patients on the CKD register and with an albumin to creatinine ratio (ACR) of 70 mg/mmol or more, without diabetes, who are currently treated with an ARB or an ACE inhibitor.*

CF presented the rationale for this indicator and gave an overview of the stakeholder consultation feedback.

In response to consultation feedback, the committee was asked to consider the following:

* Should the indicator progress to the NICE menu as suitable for inclusion in the QOF?

The committee noted that this indicator would prove valuable as a preliminary to work on SGLT2 inhibitors for people with CKD.

Members considered whether there should be a definition of persistent proteinuria within the specification. The committee noted that an ACR of 70 mg/mmol or more is abnormal and unlikely to be transient and so a definition of persistent proteinuria is likely not needed.

The committee considered whether the indicator should cover people with CKD stages 1 and 2. The committee advised that the indicator does not need to cover this population. They highlighted that the CKD register in general practice does not include stage 1 and 2 and that such patients caused by structural abnormalities or genetic risk would be expected to be managed under secondary care.

The committee discussed the impact of lower uptake of ACR testing. They advised that a minority of patients will not be able to provide a sample. It was suggested that this indicator may not be suitable for use in primary care as the numbers for the denominator may be too low. The NICE team suggested that real-world data could be used to estimate denominator numbers.

**ACTION: NICE team to undertake further analysis to understand the denominator size for IND 2022-136.**

IND 2022-137:

*The percentage of patients on the CKD register and with an albumin to creatinine ratio (ACR) of 70 mg/mmol or more, without moderate or severe frailty, in whom the last blood pressure reading (measured in the preceding 12 months) is less than 125/75 mmHg if using ambulatory or home monitoring, or less than 130/80 mmHg if monitored in clinic.*

CF presented the rationale for this indicator and gave an overview of the stakeholder consultation feedback.

In response to consultation feedback, the committee was asked to consider the following:

* Should the indicator progress to the NICE menu as suitable for inclusion in the QOF?

The committee considered stakeholder comments on consistent frailty identification. Concerns were raised that current general practice coding lacks some accuracy in diagnosing those with moderate to severe frailty which presents a risk of false positives particularly for the moderate group. Members noted the use of the electronic frailty index which is used to produce a standard score and GMS guidance require a 2-step process to determine frailty. It was highlighted that there would be a heavier reliance on clinician assessment by including those with moderate frailty. The NICE team highlighted ongoing work on frailty in relation to the current hypertension indicators to be presented to the committee in December 2022.

Members suggested that there would need to be validation on population numbers to ascertain at what level this indicator should operate at. It was suggested that the indicator could operate at primary care network or integrated care system.

**ACTION: NICE team to undertake further analysis to understand the denominator size for IND 2022-137.**

**Item 8 - Review of decisions**

MM confirmed details of the business and all recorded decisions and actions discussed had been noted.

**AOB**

None.

**Close of meeting**