# National Institute for Health and Care Excellence

### Indicator Advisory Committee meeting minutes

**Date:** 6 June 2023

**Location:** NICE Manchester office with virtual attendees via Zoom (hybrid)

**Attendees:**

**Indicator Advisory Committee members:**

Ronny Cheung (RC) [Chair], Andrew Black (AB) [Vice Chair], Chloe Evans (CE), Martin Vernon (MV), Mary Weatherstone (MW), Mieke Van Hemelrijck (MVH), Rachel Brown (RB), Tessa Lewis (TL), Victoria Welsh (VW), Waqas Tahir (WT), Chris Wilkinson (CW), Paula Parvulescu (PP), Kate Francis (KF), Liz Cross (LC), Elena Garralda (EG), Adrian Barker (AB), Linn Phipps (LP)

**NICE attendees:**

Craig Grime (CDG), Rick Keen (RK) [minutes], Mark Minchin (MM), Charlotte Fairclough (CF), Victoria Fitton (VF), Nicola Greenway (NG), Jean Bennie (JB), Lyn Davies (LD) [host]

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

Andrea Brown (ABr), Kate Thurland (KT), Tony Roberts (TR), Ellie Mitchell (EM)

**NHS England (NHS Digital):**

Laura Corbett (LC), Heather Taylor (HT)

**External experts:**

Joe Mills (JM), NICE Guideline Group Chair – Lipid modification

Smeeta Sinha (SSi), National Clinical Director Renal Services

**Apologies:**

Ben Anderson, Dominic Horne, Michael Bainbridge, Raju Reddy, Chris Gale

**Quoracy:** the meeting was quorate.

**Outline of the meeting**

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

**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.

VW - Chief Investigator for research: Experiences of managing pain with opioid medications in adults aged 85 years and older. Funded by the NIHR School for Primary Care.

RC noted that WT has declared interests relating to items being discussed today (item 2, lipid modification and item 4 SGLT2i). It has been agreed that WT will remove himself from the meeting for these discussions.

**Item 1 - Review of minutes and actions from December 2022 meeting**

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

The December 2022 minutes were approved as an accurate record.

**Item 2 – Non-HDL treatment target: CVD**

Private session, due to the committee discussing unpublished guidance.

**Item 3 – Overview of items 4 to 6**

CDG presented to the committee an overview of new indicators on learning disabilities, familial hypercholesterolaemia (FH), and SGLT2i inhibitors for people with chronic kidney disease (CKD).

CDG explained the development process for these indicators, including open consultation and discussion at focus groups with GPs. It was noted that the FH indicator had not previously been discussed by the committee but had been included in this development cycle following approval from the committee chair.

CDG noted that there was a low response to the consultation. It was highlighted that demands on the healthcare system are affecting consultation responses in general. The NICE team noted that key stakeholders were contacted directly such as NHS England (NHSE) and the British Medical Association (BMA).

CDG noted that focus groups had been used to obtain individual GP feedback, as an alternative to the usual piloting undertaken by the National Collaborating Centre for Indicator Development. The main driver for this was the shortened timescales available. Committee members queried if there was a risk of under representation particularly from practices in deprived areas.

**Item 4 – CKD: SGLT2 inhibitors**

CF presented to the committee three new indicators on SGLT2 inhibitors for people with CKD:

*The percentage of patients on the CKD register and currently treated with an ARB or ACE inhibitor who are also currently treated with an SGLT2 inhibitor if they have either:*

IND2022-142

* *a urine ACR of 22.6 mg/mmol or more*
* *type 2 diabetes and a urine ACR over 30 mg/mmol.*

IND2022-135

* *a urine ACR of 22.6 mg/mmol or more*
* *type 2 diabetes and a urine ACR 3 mg/mmol or more.*

IND2022-143

* *a urine ACR of 22.6 mg/mmol or more*
* *type 2 diabetes.*

SSi noted her declared interests and presented to the committee the background on SGLT2 inhibitors to treat CKD. SSi outlined the scope for quality improvement in this area and highlighted the recent Kidney Research UK report published in June 2023 that highlighted that kidney disease accounts for 3.2 percent of the NHS budget. It was noted that without early detection and intervention, current UK modelling predicts ten thousand premature deaths from CKD by 2033.

SSi acknowledged the difficulties in primary care and noted that via the Renal Services Transformation Programme (RSTP), integrated models have been developed within renal services across all NHSE regions. It was highlighted that there is a focus to move away from GPs towards nursing and pharmacies for long-term condition monitoring.

SSi noted the benefits of indicators for people with CKD including on urine ACR measurement and the push to improve coding. SSi discussed the evidence on the outcomes associated with SGLT2 inhibitors in CKD. SSi highlighted the [NICE technology appraisal on empagliflozin for treating CKD](https://www.nice.org.uk/guidance/indevelopment/gid-ta11170) that is in development and noted the impact that this could have on any proposed indicator for SGLT2 inhibitor prescribing that uses a urine ACR value in a denominator. The updated UK Kidney Association guidelines on SGLT2 inhibitors in CKD were highlighted to the committee.

CF highlighted the data received from the Clinical Practice Research Database (CRPD) Aurum which showed how many patients on the CKD register had a urine ACR result, prescription of ACE inhibitors or angiotensin receptor blockers (ARBs) and SGLT2 inhibitors, and estimated denominator numbers for the 3 draft indicators (up to March 2022).

CF presented the following considerations based on consultation and focus group feedback:

* Potential limited experience of prescribing SGLT2 inhibitors for CKD in general practice.
* Compromises in the specification including use of CKD register and last recorded urine ACR.
* The impact of low rate of urine ACR testing and prescription of ACE inhibitor/ARBs.
* The issues with coding of CKD, type 2 diabetes and urine ACR.
* The potentially small denominator numbers shown by CPRD data, dependent on requirement for urine ACR in patients with type 2 diabetes.
* Dapagliflozin is currently the only SGLT2 inhibitor used for treating CKD. Empagliflozin for treating CKD is currently under NICE appraisal. Other SGLT2 inhibitors may be used for other indications.

The committee was asked to consider which of the indicators should progress to the NICE indicator menu as suitable for use in the QOF, or if the indicators should be delayed or halted.

Members considered the low prescribing percentages of SGLT2 inhibitors for CKD patients from CPRD Aurum may be out of date considering NICE guidance on dapagliflozin was published in November 2021 and general practice would not prescribe without guidance support. The rate of prescribing of ACE inhibitors or ARBs seen in CPRD Aurum was potentially attributed to poor coding of CKD in patients with hypertension.

The committee discussed prescribing in general practice and commented on stakeholder concerns about the potential for diabetic ketoacidosis associated with the use of SGLT2 inhibitors. They noted that prescribers need inform patients of the ‘sick day rules’ which will vary between patients depending on their lifestyle and diet. SSi highlighted that this work is already underway via the RSTP with renal networks providing patient information and searches, as well as helping identifying CKD patients for GPs who should be on the CKD register. It was noted that each network will support this programme and that an indicator has a potential to bolster this work by providing a financial incentive.

Members considered stakeholder comments querying whether these indicators would be suitable for measurement in general practice. It was noted that despite the workload pressures and uncertainty, primary care would be best placed for these indicators given that it already has holistic conversations with CKD patients regarding the ‘sick day rules’, and already prescribes SGLT2 inhibitors for diabetes and heart failure. It was highlighted that renal network support would mitigate the workload pressures, and there was acknowledgement of greater need for secondary care support.

The committee considered whether these indicators should include consideration to frailty coding and patients with multimorbidity. SSi suggested that SGLT2 inhibitor usage is well tolerated and has shown to decrease the risk of hospitalisation for older heart failure patients which may be replicated for older CKD patients, though acknowledged a transient reduction in eGFR when first prescribed. It was highlighted that a personalised care adjustment would be suitable approach for frail and multimorbidity patients. SSi suggested that there is low risk of renal harm in using these inhibitors based on available evidence.

Members raised concerns over the low rate of urine ACR testing and it was noted that an indicator on SGLT2 inhibitor prescribing that requires a urine ACR value for inclusion in the denominator cannot be a standalone indicator; it would need to sit parallel to a CKD ACR indicator. The need for a urine ACR value for ACE inhibitor and ARB prescribing was also discussed and the committee discussed the need for implementation of other indicators on CKD, such as urine ACR and prescribing ACE inhibitors. The committee discussed whether publication of an indicator on SGLT2 inhibitors should be delayed until the NICE TA on empagliflozin for treating CKD is published but it was noted that this would be a year delay. The committee discussed the potential for piloting the three indicators to ascertain the primary care workload, to see if there is an improvement in recording of urine ACR measurement and prescribing of ACE inhibitors or ARBs, and to explore the complexity of coding suggested by stakeholders but agreed that piloting would most likely not provide any more useful information beyond the data already available and the expertise of the committee.

The committee discussed the appropriate measurement level for an indicator, for example primary care network or general practice level, and thought that having three indicators on the NICE menu may be confusing and it would be best to publish the option with the most robust evidence base, in this case draft IND2022-142. It was noted that the estimated denominator is too small for a potential QOF indicator at the moment (based on data from CPRD Aurum) but could be impacted by an increase in urine ACR testing. SSi confirmed that there is robust evidence in support of all three indicators, and that any indicator progressing on SGLT2 inhibitors would support improvements in care and outcomes. The NICE team emphasised that the draft indicators are based on NICE guidance; IND2022-142 based on an offer recommendation in NICE’s guideline on type 2 diabetes in adults, IND2-220135 a consider recommendation in this guideline and IND2022-143 based on NICE TA775. The committee discussed whether an indicator should focus on patients with CKD, regardless of coexisting type 2 diabetes but the committee noted the strong evidence in this population. The committee agreed to progress draft indicator IND2022-135 as the population includes people with lower levels of proteinuria and the estimated denominator number is potentially suitable for inclusion in QOF. The committee discussed the use of a “consider” recommendation. The NICE team suggested that IND2022-135 could progress as a quality improvement indicator to the NICE menu with further work required to ascertain its suitability for use in the QOF and potential to update this as new NICE recommendations or technology appraisals are published.

**ACTION: NICE team to progress IND2022-135 to the indicator menu for use outside of the QOF. Indicator to be reviewed when guidance on empagliflozin has been published.**

**Item 5 – Learning disabilities**

CDG presented to the committee two potential new indicators on learning disabilities that originate from the Impact and Investment Fund (IIF):

IND2022-129: *The percentage of patients on the learning disability register aged 14 or over, who received a learning disability health check and a completed health action plan in the preceding 12 months.*

IND2023-152: *The percentage of patients on the learning disability register aged 14 or over, who:*

* *received a learning disability health check and a completed health action plan in the preceding 12 months and*
* *have a recording of ethnicity.*

CDG noted that the only difference between the indicators is the requirement for a recording of ethnicity in IND2022-152. It was highlighted that there is value in using the two side by side to allow an understanding of which component (provision of an action plan or recording of ethnicity) is affecting performance.

CDG highlighted the latest available data and reported on consultation and focus group feedback.

The committee was asked to consider whether these indicators should progress to the NICE indicator menu as suitable for use in the QOF, development halted or if further evidence of their validity was required.

The committee agreed that the indicators have the potential to improve health outcomes for people with a learning disability, Members noted the importance of ethnicity recording given existing health inequalities in premature mortality. It was noted that inequalities are a result of multiple societal factors but the committee reflected on the value of ensuring health needs are reviewed regularly.

The committee discussed the accuracy of the underpinning register. The NICE team suggested that NEQOS could investigate how the accuracy of the learning disabilities register can be improved.

Members discussed feedback on the potential for the provision of action plans to be a ‘tick box exercise’ and recommended that the accompanying documentation signpost the Oliver McGowan mandatory training in learning disabilities and autism and existing guidance on the content of the action plan.

The committee considered if the indicators should include people under 14, noting that there is currently no age restriction on the QOF learning disability register.

**ACTION: NICE and NEQOS to investigate the accuracy of the learning disabilities register and any potential improvements.**

**ACTION: NICE to pause publication of IND2022-129 and IND2023-152 and explore the potential to include people under 14.**

**Item 6 – Lipid disorders: FH assessment and diagnosis**

*IND2022-130: The percentage of patients with a total cholesterol reading greater than 7.5 when aged 29 years or under, or greater than 9.0 when aged 30 years or over, who have been:*

* *diagnosed with secondary hyperlipidaemia or*
* *clinically assessed for familial hypercholesterolaemia or*
* *referred for assessment for familial hypercholesterolaemia or*
* *genetically diagnosed with familial hypercholesterolaemia.*

CDG highlighted the latest available data and reported on consultation and focus group feedback.

The committee was asked to consider whether the indicator should progress to the NICE indicator menu as suitable for use in the QOF, halt development or if further evidence of its validity was required.

The committee discussed the construction of the indicator, specifically noting that it does not only focus on recent readings (for example within the last 12 months). There was support for this approach until diagnosis rates of FH improve and it was noted that an indicator focused only on readings in the previous 12 months would be likely to results in small numbers per practice and therefore be unsuitable for inclusion in the QOF.

The committee agreed that some spurious results may be returned, but that appropriate action and subsequent coding should be taken as FH remains underdiagnosed.

It was agreed that the accompanying documentation should highlight that fasting samples are the most accurate.

The committee noted concerns around the resulting impact on specialist services, especially in the first year of implementation.

**ACTION: NICE team to progress IND2022-129 to the NICE menu for inclusion in the QOF with the addition of a new indicator for use outside the QOF focused on readings in the previous 12 months.**

**Item 7 - Existing indicators NM113 and NM123**

*NM113: The contractor supports patients who smoke in stopping smoking by a strategy which includes providing literature and offering appropriate therapy.*

CDG highlighted that the indicator was retired from QOF in 2020 as it was considered core professional practice that did not require incentivisation. It was noted that the indicator appears to be a ‘tick box exercise’ that does not provide adequate information to support quality improvement. It was highlighted that the NICE menu and QOF contain more useful indicators that focus on provision of stop smoking interventions to relevant populations.

The committee was asked to consider retiring NM113 from the NICE menu given the limited value it provides for quality improvement.

**ACTION: NICE team to retire NM113 from the NICE menu.**

*NM123: The percentage of patients with a new diagnosis of depression and/or anxiety disorder in the preceding 1 April to 31 March, whose notes record an offer of referral for psychological treatment within 3 months of the date of diagnosis.*

CDG noted that this indicator was never added to the QOF. It was highlighted that NICE’s guideline on depression was updated in 2022 and includes a range of treatments for new episodes of depression with a stronger focus on patient preference. It was noted that self-referral for psychological therapies has become more commonplace.

The committee was asked to consider retiring NM123 from the NICE menu as it no longer aligns with NICE guidance.

The committee agreed that this indicator should be retired from the NICE menu, but that a replacement will be needed that better reflects the range of appropriate interventions. The NICE team suggested that the depression update quality standard, due to be published in June 2022, could be used to identify other potential indicators. CDG asked if any potential indicators should continue to include both depression and anxiety. The committee confirmed this would likely be appropriate given the overlap in diagnoses and interventions.

**ACTION**: **NICE team to retire NM123 from the NICE menu. Potential new indicators for depression and anxiety be brought back to a future committee.**

**Item 8 - Review of decisions**

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

**Item 9 – NICE updates**

Private session.

**AOB**

Private session.

**Close of meeting**