Indicator Advisory Committee Meeting

Unconfirmed draft minutes of the meeting held on Wednesday 9th December 2015

NICE Office, Manchester

Attendees	**Committee Members:** Daniel Keenan (DK) [Chair], Andrew Anderson (AA), Andrew Black (AB) [Vice Chair], Rachel Brown (RB), Kate Francis (KF), Christopher Gale (CG), Richard Garlick (RG), Elena Garralda (EG), Peter Holt (PH), Dominic Horne (DH), Jo Jerrome (JJ), Tessa Lewis (TL), Paul Lord (PL), Jan Norman (JN), Allison Streetly (AS), Martin Vernon (MV), Mary Weatherstone (MW), Paula Whitty (PW) Simon Hairsnape (SH), Linn Phipps (LP), Bill Taylor (BT) and Emily White (EW). **Co-opted Committee members:** Matt Fay (MF) and Roger Gadsby (RG) **NICE Attendees:** Brian Bennett (BB), Nicola Bent (NBe), Gavin Flatt (GF), Laura Hobbs (LH), Shaun Rowark (SR), Mark Minchin (MM), Karen Slade (KS), Alison Reddicen (ARe) and Roshni Joshi (RJ) **NICE Collaborating Centre for Indicator Development (NCCID):** Paramjit Gill (PG), Rachel Foskett-Tharby (RFT) and Nick Hex (NH) **Health and Social Care Information Centre (HSCIC):** Alison Roe (AR) and Chris Dew (CD) **NICE Observers:** Steph Birtles, Anneka Patel, Jay Stone, Tara Chernick
Apologies	Nigel Beasley, Ronny Cheung, Maeve Lamb, Jan Giles, Tony Kendrick and Robert Walton

Agenda item	Discussions
1. Outline of meeting	DK welcomed all attendees and the Committee members introduced themselves. DK welcomed Dr Matt Fay to the meeting. Dr Fay is a GP with a specialist interest in the identification and treatment of atrial fibrillation (AF) and has joined the Committee for this meeting as a co-opted member. DK advised the Committee that Professor Roger Gadsby would be joining the meeting after lunch to help inform the discussion on diabetes. DK provided the outline of the meeting advising it will be taking a pathway approach for AF and diabetes discussions and will identify potential indicators that the Committee wish to explore further. DK highlighted that no decisions will be made at this Committee meeting about any new additions to the NICE indicator menu and that today's items were about exploring potential new indicators, some of which may go forward for further development. Apologies were noted.
2. Introduction to the meeting and Code of Conduct for members of the public attending the meeting	DK briefed the Committee and the public observers on NICE's code of conduct for meetings held in public.

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3. NICE advisory body declaration of conflicts of interest	DK asked the Committee to declare any interests that were either in addition to their previously submitted declaration, or specific to the topic(s) under consideration at the meeting today. The following interests were declared: • MF declared he is a trustee of the AF Association and advisor for the National Stroke Association and he has been funded for his time out of practice to provide anticoagulation advice to the pharmaceutical industry. • TL declared she provides advice on anticoagulation to the Welsh Health Department. • PH declared he is funded by the NIHR for research into outcomes in vascular surgery. • PW advised she has no conflict with discussion topics today but wanted to declare a conflict with DK as her team are engaged in a tender with HQIP - DK is medical director at HQIP. Details of the above interests have been provided to NICE.
4. Review of minutes and actions from the June IAC meeting	DK asked members for any inaccuracies in the minutes for the meeting held in September 2015. The minutes were approved as an accurate record of the meeting. The Committee was provided with a table containing all the actions from the September meeting with an update for each action. BB went through some of actions where further input was needed from the Committee.
i. Anxiety disorders	AR advised they have worked with the Improving Access to Psychological Therapies (IAPT) clinical lead with input from Tony Kendrick to agree the process for developing and testing a validated definition of “returning to full function”. It is hoped that this work will be ready for testing in the summer next year. Some of this will rely on new datasets being collected for IAPT, which are due to come on line in August 2016. Once this data are available further analysis will be carried out and the Committee updated.
ii. Prevention	BB referenced 3 areas suggested at the last meeting where prevention focused indicators could be considered. The first 2 are AF and diabetes and both are on this meeting’s agenda. The third suggestion was suicide prevention. BB advised the Committee that NICE intends on developing new guidance on suicide prevention and therefore proposed that the Committee wait until that guidance is published and then to use this as the evidence source for any potential indicators. The Committee agreed with this proposal.
iii. Patient decision aids	BB advised that RFT and colleagues have been investigating the feasibility of developing indicators focused on the use of patient decision aids and the broader area of shared decision making. This work will be brought to the April 2016 meeting of the Committee.

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iv. Learning disabilities and autism	BB went through a number of actions concerning autism and learning disabilities: i. In terms of the development of a Primary Care Register for people with autism, BB advised that he had been in contact with the Royal College of General Practitioners (RCGP) clinical priority group on autism and RFT had been looking at the feasibility of indicators in this area. When investigating whether there was evidence of health inequalities in people with autism but without a learning disability, BB noted that there is not a large amount of information published as this population is not currently consistently recorded. **Action**: The Committee agreed that in the first instance a register of people with autism could be investigated by NICE and the NCCID, consulting with a broad range of community based autism groups to request feedback about any issues associated with being included on the GP register. Feedback on this will be brought back to the Committee at a future meeting. ii. The Committee had previously discussed the potential of having an indicator concerning health checks for people with learning disabilities and / or autism. BB noted that for people with autism, the NICE recommendations focus on the need for physical and mental health checks being incorporated into the diagnostic assessment rather than there being a need for regular health checks. However, there are recommendations and a directed enhanced service for people with a learning disability to have annual physical health checks. **Action**: It was therefore agreed that in the first instance an indicator concerning health checks for people with a learning disability should be further investigated and potentially piloted. And that once feedback is received about the proposed general practice register of people with autism that an indicator concerning a health check at diagnosis is considered. iii. With regards to the prescribing of antipsychotic medication, RFT reported that she had reviewed some of the published literature in this area and one research project had identified 200 different codes for situations where antipsychotic medication was prescribed. In some cases, the rationale for the diagnosis could have been given in a free text box. It was therefore suggested that currently an indicator in this area would not be feasible as it would be extremely difficult to gather reliable data, it was therefore agreed that this would not be progressed at this stage. iv. BB advised the Committee that AR and her team had been investigating proposed indicators concerning ‘in-appropriate’ admissions amongst this population. AR requested that the Committee clarify whether they would like the indicators to focus on a) admissions into general acute inpatient services and / or b) admissions into mental health (MH) services. AR advised that the MH data set comes into place in January 2016 which will provide additional information including Child and Adolescent Mental Health Services (CAMHS) data. AA asked that the wording refer to unplanned admissions rather than ‘inappropriate’. This was agreed by the Committee. The Committee then discussed the issue of identifying the relevant population and how those with autism and no learning disability would not be

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	identified if using the current primary care register. AB supported the development of indicators in this area as there is evidence that this population are receiving poor levels of care and presenting to A&E services. JN stated that there are local initiatives focused on this population and that this could provide information to support the development of indicators in this area. **Action**: DK summarised and asked that NICE and HSCIC look into what would be feasible and develop the indicators further, bringing them back to a future meeting.
v. Heavy menstrual bleeding (HMB)	BB provided an overview of the actions concerning HMB from the previous meeting. The main issue had been which diagnostic codes should be included in a denominator for a HMB indicator. AR confirmed that a meeting had taken place between representatives from NICE including a consultant obstetrician who has been an expert adviser for related guidelines, RB from the IAC and representatives from the HSCIC including some of their coding experts. It was agreed that ICD-10 code D25 for fibroids should be included in the denominator. At this meeting, there was discussion about whether the indicators that were originally proposed were the best measures of quality improvement. The view was that the best indicators would focus on patient reported satisfaction and whether a discussion was had about different treatment options. There were discussions about what would be deemed good in relation to hysterectomy rates as assuming that a low rate is a good thing may not necessarily be accurate and fair. However, it was noted that if different hospitals had very different rates of the available interventions, then this is something that a commissioner would be interested in. The rates of different interventions should also be standardised for different demographic groups. **Action –** It was agreed that NICE would work with HSCIC to assess whether a CCG level indicator would be feasible looking at rates of different interventions and to also investigate the potential of patient satisfaction / patient reported outcomes indicators in this area.
5. King's Fund and Health Foundation reviews of metrics in the health care system	MM provided an overview of 2 reports from the King's Fund and the Health Foundation concerning the development and use of metrics in the NHS. MM noted that both reports had been very positive about the process NICE uses to develop indicators and the role of the Committee was specifically referenced. A number of recommendations were made in the reports and NICE are engaged in some initial work with key partners to take this forward. The Committee will be informed of any developments as they arise. PW thanked MM for his summary. She supported the recommendation that there needs to be an underlying quality strategy to focus this work. PW also supported the proposed around the merging of the Outcomes Frameworks, something that was also supported by RG and AS. PW highlighted the potential challenge in developing indicators that go beyond the traditional issues and how a broader definition of quality will require a broader range of indicators for example organisational culture – which will

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	be a challenging area to develop indicators in.
6. The role of the NICE indicator menu	MM presented an overview of the NICE indicator menu and highlighted that the QOF and CCG OIS menus are published annually and cover a range of topics that can be used in national and local indicator frameworks. MM reported that there are currently 56 out of 119 indicators from the NICE menu are included in live QOF (56/75) (2015/16) and 36 out of 61 indicators from the NICE menu are currently in the CCG OIS (36/61) (2015/16). BT asked how NICE was promoting the menu and the potential uses the indicators have beyond the QOF and CCG OIS. The Committee referenced examples of where CCG's were developing their own indicators and if there was greater awareness of the NICE indicator menu, then it would reduce the need for local areas to have to develop their own indicators. MM confirmed that NICE is looking at how best to promote the menus and their potential use in initiatives such as local quality improvement schemes and CQUINs.
7. Review of potential NICE indicators for CCG's	GF provided background on the item. He advised the Committee that the NICE team had reviewed a number of indicators which had previously been through the indicator development process for the CCG OIS. These indicators could not be proposed for the NICE indicator menu as at the time they had not been feasible due to the lack of a national data source. However, following a review and input from colleagues at the HSCIC potential data sources for 7 indicators have been identified. These 7 indicators were presented to the Committee for consideration. i. **Depression**: *“People with new presentation of depression who receive appropriate treatment”* GP noted that the purpose of this indicator would be to measure whether people with a new presentation of depression receive appropriate treatment. AR advised that this indicator could be supported through the use of the IAPT annual report dataset that records therapy type. The Committee questioned the term “appropriate” as this is open to a number of definitions and whilst the IAPT data set would have a list of therapy types this would be quite restrictive. This indicator would also need to consider the service users' perspective as to what was deemed to be appropriate. The Committee agreed that access to mental health services is clearly an important area for indicator development and should be investigated further; including looking at the feasibility of getting patient / service user reported outcome measures. The importance of people with depression being given treatment options was highlighted as well as the need to consider how an indicator in this area could potentially link with the recently developed NICE menu indicator for QOF concerning referral to psychological services for people with depression and / or anxiety. **Action**: DK summarised, asking the NICE and HSCIC to further investigate developing potential indicators in this area,

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	looking at treatment options, the number of people being referred and then accessing treatment. Service user/patient reported outcome indicators to be considered also. ii. **Dementia**: "*Staff who work with people with dementia who have had dementia care training.*" The focus of this indicator would be to ensure staff working with people who have dementia are appropriately trained to ensure they have the skills required to provide high quality care. The Committee questioned how dementia care training would be defined. EW highlighted that this would depend on the type of service being provided. For example you would expect organisations providing specialist dementia services to have staff with recognised training and qualifications in supporting and caring for people with dementia. The National Minimum Data Set for Social Care (NMDS-SC) was noted as a potential data source as this does record staff training. However, this would be very social care focused and it was unclear the contribution CCGs could have in helping to achieve this indicator. It was also noted that the severity of dementia varies so the level of training staff have received needs to reflect the severity of symptoms being experienced by those in their care. DH noted that staff training sits within the CQCs remit. DK summarised, confirming that the Committee has agreed that this indicator should not go forward in its current format. He suggested that dementia care is an important area and that further exploratory work should be carried out to look at what the current data collections are focused on and whether these would support indicators for quality improvement. A general comment was made by LP asking that the rationale for each indicator clearly states what the anticipated impact on the care of people and their outcomes would be. This was agreed by the Committee and the NICE team will include this in the framework used to present supporting information for indicators being discussed at the Committee in the future. **Action**: HSCIC and NICE to review current data sets and work with a Committee subgroup to consider potential indicators in this area and bring this back to a future Committee meeting. iii. **Breast cancer:** *"Patient satisfaction with outcome of breast surgery"* GF advised that a dataset may now be available to support an indicator focused on patient satisfaction of people having surgery for breast cancer. AR stated this information could be broken down for the main cancer types including breast cancer, lung, bowel etc. The Committee discussed the content of the National Cancer Patient Experience Survey that would provide the data to support these indicators. It was noted that the information in the

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	survey is focused on the provision of information and that it would not be accurate to describe this as measuring satisfaction or experience. There was a consensus that this was a very important area and that further work should be done to look at what is in the survey and what potential indicators the survey could support. **Action**: NICE / HSCIC to look at the National Cancer Patient Experience Survey to identify potential indicators the survey could support. iv. **Antenatal care 10wks**: *"The proportion of pregnant women accessing antenatal care who are seen for booking by 10 weeks 0 days"* GF advised the Committee that there is a currently an indicator in the 2015/16 CCG OIS concerning the proportion of pregnant women accessing antenatal care at 13 weeks gestation, GF noted that the current average achievement level for this indicator is 95%. The Committee was therefore asked whether they want to progress an indicator focused on the proportion of pregnant women accessing antenatal care within 10 weeks. AR advised that there is a new data source that would support a 10 week indicator that has come on line, though it is classed as experimental statistics for at the moment until data quality and completeness can be verified. AS commented that this fits with a PHE priority and strongly supports the proposed 10 week indicator. AB proposed to run both the 10 and 13 week indicators in parallel initially and then potential drop the13 week indicator once the 10 week indicator becomes established. DK summarised stating that the Committee has agreed to progress the 10 week indicator, recommending that it runs alongside the 13 week indicator in the first instance. **Action**: NICE to take the proposed indicator forward with the HSCIC for testing. **v. Venous thromboembolism (VTE): Mortality** AR advised that this indicator was previously not taken forward due to issues concerning the clinical coding of VTE. However, the Committee was advised that the NHS Clinical Classifications Services had provided a list of potential ICD-10 codes that could be used to support an indicator in this area. The Committee discussed whether a broader indicator or set of indicators could be considered that look at the issues that precede death from VTE and that this is quite a complex area with regards to attribution as people can often present at hospital with VTE developed in the community rather than develop it at hospital. It was agreed that the first step should be for the HSCIC to investigate the actual number of deaths coded as being due to VTE to assess whether this could be an outcome measure that could then be linked to some process / intermediate outcomes.

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	Action: HSCIC to review number of deaths from VTE using the agreed ICD-10 codes. Further work also to be done on clarifying the intent of the indicator, that is, should this be based on hospital deaths excluding cases from the community.
8. Review of potential NICE indicators for atrial fibrillation	SR provided a brief overview of AF. He took the Committee through a description of how the current NICE indicators for AF map onto a care pathway. This helped identify areas where there aren't currently any NICE indicators. The Committee was asked to consider whether indicators should be developed for the following areas. As part of the discussions and decision making process the Committee was asked to consider whether any proposed general practice indicators should be considered for incentivisation or whether they would be more suitable as quality improvement measures: i. **Identification of people with undiagnosed atrial fibrillation:** SR described evidence that there are thought to be up to 440,000 people in England currently with undiagnosed AF and that the best way to identifying this group is through carrying out a manual pulse palpation. SR advised the Committee that the current NICE guidance for AF doesn't make any specific recommendations about case finding. However, SR noted that NICE guidance does cover the measurement of blood pressure in certain populations, and best practice for measuring blood pressure is to perform a manual pulse palpation. SR also highlighted that in July 2014 the National Screening Committee did not recommend systematic population screening. MF highlighted that when the NICE guidance (CG180) was recently updated, it did not include case finding of people at risk of AF due to the scope given to guideline developers. From his perspective this has led to a gap in the guidance. The Committee discussed what population should be targeted to carry out pulse palpation and also discussed the work load implications of doing the assessment and then carrying out an ECG to confirm AF. The Committee also noted the implications of not identifying people with AF who then go on to have a stroke and the effect this has on the patient and the resource implications on general practice and the wider NHS. The Committee considered the following populations for targeted case finding, noting that the risk of AF increases with age: • all people over 65 • all people over 65 with co-morbidities - hypertension, diabetes, CKD, PAD, previous stroke or COPD (covers 56.3% of those over 65) • all people with co-morbidities The Committee recognised the potential implications these indicators could have on the work load within general practice. A number of members suggested that this should occur as part of any routine review for people with co-morbidities and even those who didn't have any diagnosed conditions but were over 65 are likely to visit their GP several times a year, during one of these visits a manual pulse palpation could be completed.

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	Following a discussion of the different options, DK summarised the discussion, confirming that the Committee had reached a consensus that 2 indicators should be further investigated, one focusing on an annual manual pulse palpation being performed in those over 65 with pre-defined co-morbidities and one concerning opportunistic case finding in those over 65. DK also confirmed with the Committee that these indicators would be best suited for quality improvement in the first instance, rather than an incentivised QOF indicator. **Action:** NICE/NCCID to develop indicators for general practice quality improvement focused on the following areas: • The proportion of people over 65 with co-morbidities (hypertension, diabetes, CKD, PAD, previous stroke or COPD) who have a manual pulse palpation in the previous 12 months • The proportion of people over 65 who have a manual pulse palpation. **ii. Do not do indicator - Use of aspirin monotherapy solely for stroke prevention:** SR reminded the Committee that the NICE guideline for AF included a ‘do not do recommendation’ concerning the use of aspirin monotherapy for stroke prevention in people with AF. SR also referenced evidence from the 2014-2015 Sentinel Stroke National Audit Programme (SSNAP) that suggests 33.7% of patients with AF who present with a stroke are taking aspirin monotherapy for stroke prevention. The Committee was therefore asked whether it would be useful to develop an indicator focusing on reducing the number of people on aspirin monotherapy for stroke prevention through a ‘do not do’ indicator. The Committee was aware that aspirin monotherapy for stroke prevention was previously incentivised through the QOF and has become embedded in practice. The Committee heard that patients could be taking aspirin for other purposes, making measurement challenging. Therefore it was agreed that this could cause complications with regards to coding of any indicators. It was felt that this issue was more relevant to local prescribing / medicines management processes rather than having a negative indicator. DK summarised, stating that the Committee agree that this is something that CCG medicines management teams should be concerned with and that it wasn’t appropriate to progress as an indicator at this time. No further action is therefore required for this indicator. **iii. Anticoagulation:** The use of different types of anticoagulants to reduce stroke risk in people with AF were discussed, with SR asking whether an indicator should be considered around the use of non-vitamin K antagonist oral anticoagulants (NOACs).

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	SR highlighted that currently there are very high levels of variation between CCG's concerning the usages of NOACs in comparison to the use of the more traditional vitamin K antagonists – usually warfarin. Data was presented from NHS England's medicine optimisation dashboard showing that the current CCG range for prescribing NOACs vs warfarin is 1.4% to 62.1%. SR noted that NICE guidance (CG181) states the choice of anticoagulant should be made following an informed discussion between the clinician and the person receiving treatment. Some Committee members noted that NOACs are more expensive than warfarin, and that there may be issues in some areas about access to NOACs. It was noted that a lot of anticoagulation clinics are now provided by secondary care so this would need to be considered when any indicators were being developed. Whichever anticoagulant a patient is taking the Committee agreed that the patient should have an understanding of the options available to them and be able to have ongoing discussions about the options and make an informed choice about which anticoagulant they should take. DK summarised, stating that the Committee had agreed that there are concerns about availability of all options of treatment and that therefore an indicator focused on an annual discussion between the GP and patients about the treatment options for anticoagulation should be piloted as a potential indicator for incentivisation. **Action**: NICE and the NCCID to develop and pilot an indicator for incentivisation focused on – the proportion of people with atrial fibrillation who are prescribed anticoagulation who discuss the options with their healthcare professional annually. **iv. Self-monitoring of anticoagulation:** SR described to the Committee the option for people who are taking warfarin to be able to self-monitor their anticoagulation rather than having to attend an anticoagulation clinic. SR therefore asked the Committee whether this is an area that could be suitable for an indicator. It was also noted that self-monitoring had recently been included as a developmental quality statement in the NICE quality standard for AF, recognising that there is not universal access to coagulometers. The Committee did note that this should be an option for patients where this may be suitable, but that this is not generally in the control of general practitioners or other providers of anticoagulation services as this is primarily a commissioning issue therefore uptake would be dependent on the local population and other such factors. It was therefore agreed not to progress an indicator in this area at this time. **v. Outcome measures for AF:** SR asked the Committee to consider potential outcome indicators for AF, suggesting the following options: • Hospital admission rates / bed days for people with AF • Stroke rates in people with AF • Mortality rates in people with AF

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	Option i. This was discussed and deemed to be too difficult to develop into a robust indicator as people being admitted to hospital with AF are also likely to have other conditions that would have caused their admission and the identification of the population would be difficult. Option ii. This was discussed and supported by the Committee. They asked that this was further developed as it was a good outcome measure concerning how well AF has been managed and or identified in patient populations. The Committee asked that an indicator is developed that looks at all types of strokes, including heamorrhagic and ischemic stroke, and minor strokes including TIAs. Option iii. Due to similar issues to option i. this outcome area was not progressed as it would be too hard to pin point this outcome to AF and the coding would become complex. **Action**: HSCIC and NICE to develop and test an outcome measure focused on stroke rates in people with AF, potentially split by type of stroke. **vi. AF Resolved**: SR explained an issue that had arisen concerning the existence of an AF resolved code within the QOF business rules that, if used, removes a patient from the AF register and therefore they would not be included in any associated indicator denominators. There is concern that this code is being used inappropriately. Analysis of The Health Improvement Network (THIN) data suggested that this code is being used on 8.7% of patient's initially recorded on the AF register. MF stated that AF cannot really be resolved. However there are some cases where the symptoms may resolve, such as, the presence of an irregular heart rate. However, once someone has had AF they are then at future risk of complications such as having a stroke and they should therefore have that risk managed accordingly. Therefore it was agreed that the code may be suitable in some circumstances when a patient has not got AF symptoms, but that when the code is used it should not remove someone from the AF register and the associated AF indicators. This needs to be managed within the QOF business rules and also highlighted in the national QOF guidance. **Action:** NICE to work with the NCCID to further explore the use of the AF resolved code and report back to the Committee**.**
9. Review of potential NICE indicators for diabetes	AB welcomed Professor Roger Gadsby (RG) to the Committee. Prof Gadsby was a GP and a specialist in diabetes. RG declared that he is the medical adviser to the National Diabetes Audit, is an adviser to the National Best Practice for Diabetes care and has also received funding by several pharmaceutical companies for projects and events regarding diabetes care. KS provided the Committee with an overview of the current NICE diabetes indicators against the diabetes care pathway. KS

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	had mapped the indicators against the different parts of the pathway and had identified the following gaps with regards to the existence of NICE indicators: • Preventing type 2 diabetes • Children and young people with diabetes • Diabetes in pregnancy • Outcomes for diabetes care **1. Preventing type 2 diabetes** KS advised the Committee that NICE and the NCCID are currently working with NHS England and Public Health England to develop indicators that will support the delivery of the National Diabetes Prevention Programme. An update on this work will be provided at a future meeting and therefore the Committee was not asked to consider potential indicators for diabetes prevention at this meeting. **2. Children and young people with diabetes** KS advised that the current diabetes indicators are restricted to those 18 years or over and that there aren't currently any indicators for children and young people. KS also noted that the vast majority of care for this population with diabetes would occur in secondary care so any indicators are likely to be CCG focused. KS explained to the Committee that the previous CCG OIS Advisory Group had reviewed a composite indicator that included the 7 care processes described in the NICE guidelines for treatment and support of children and young people with diabetes. The newly published guideline (NG18) included the same care processes and also an additional 3 areas. Therefore the Committee considered an indicator including the following care processes: • Glycated Haemoglobin A1c (HbA1c) monitoring • Body Mass Index (BMI) • Blood pressure • Urinary Albumin • Cholesterol • Eye screening • Foot examination • Smoking • Screening for thyroid and coeliac disease • Psychological assessment.

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	RG agreed that these are the key areas, but highlighted that this is quite a complex area for measurement as some of the issues identified above wouldn't manifest themselves until someone reaches puberty or where they have had diabetes for several years. It was also noted that when people become teenagers risky behavior increases the potential for complications associated with their diabetes. The Committee considered the option of looking at each individual care process in isolation and then also looking at a composite indicator. The issue of transition between children and young people's services to adult services was also highlighted as a potential area for consideration. MM advised the Committee that NICE is currently developing a quality standard on diabetes in children and young people and that this may provide a useful basis for future indicator development for transitional care issues. To summarise discussions AB asked the Committee whether they were supportive of a composite or individual indicator. Following discussion it was agreed individual indicators would be a good starting point with a view to reviewing these areas once the QS for diabetes in children and young people has been implemented. **Action**: NICE and HSCIC to test and consult on individual indicators in the first instance. **3. Diabetes in pregnancy** KS advised that the current NICE indicator for diabetes in pregnancy (NM70) applies to all women aged 17-45, and relates to pre-conception advice in general practice. However, there are many feasibility issues around defining a pregnant population as it is a transient state spanning the full term of pregnancy. Many pregnancies are unplanned and pregnant women often present to various healthcare professionals at different times. One option explored was to measure care retrospectively and use the information to develop an improvement indicator. KS advised that the quality standard for Diabetes in pregnancy is due to be published in January 2016, and the statements maybe a useful basis to develop a metric for a quality improvement indicator. The Committee discussed the prescribing of 5mg folic acid to women with diabetes who are planning a pregnancy as a possible area for indicator development. RFT suggested constructing an indicator to include the offer of folic acid, but Committee considered that the current indicator (NM70) was robust and sufficient as it included awareness raising about folic acid. JN queried as to why this message could not be communicated via the Diabetes UK networks, rather than the Committee trying to construct an indicator. RG advised that pregnancy is not part of their current agenda and some work has gone into highlighting preconception as a priority area in previous years. AA queried with the NICE team whether indicators that were previously included in the menu but not taken forward after negotiations can be highlighted to NHS England and negotiators. NB confirmed that NICE could look into this.

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	Action: NICE to look into highlighting NICE indicator NM70 to NHS England. **Action**: AR to review feasibility around pregnancy datasets. **Action:** RFT construct something for piloting, which considers prevalence at practice level and a larger population for CCG. **4. Diabetes outcomes** KS asked the Committee to consider the measurability and appropriateness of diabetes outcomes listed in the briefing paper. RG advised the Committee of a National diabetes audit pilot around patient satisfaction with care which obtained useful data. However, this has not yet been funded as a resource to collect data. AB asked for any thoughts from SH from a CCG perspective and SN advised CCG commission some services, some tertiary care, and this would raise questions for CCG. PW queried if this related to the NHS outcome framework in terms of treatment satisfaction and the Patient Reported Outcome Measures (PROMs) programme. **Action**: NICE to find out whether NHS England's work on PROMs will support the development of metrics for diabetes outcome indicators relating to patient experience. **Action**: NICE to look at which outcomes are measurable and report back to Committee.
10. Review of the general practice QOF register for chronic kidney disease (CKD)	RJ provided the Committee with an overview of the current general practice CKD register in the 2015/16 QOF. The current register is not in line with the latest NICE guideline (CG182) that has a broader definition of CKD than the current QOF register. This would therefore require a larger population of people to be included on the register, taking into account people's albumin:creatinine ratio as well as their glomerular filtration rate that the current register is based on. A new CKD register that encompasses people in the current register as well as those in the expanded groups is now being piloted and the results will be reviewed by IAC in June 2016. A number of GPs suggested the current register is already too broad and that it includes people in who will naturally see an age related reduction in their kidney function. The Committee discussed the importance of not over medicalizing people and their conditions, but also the importance of preventing CKD becoming severe and leading to kidney failure. The Committee asked NICE to work with the expert advisers on the guideline team that developed CG182 to better determine the benefits of expanding the QOF register.. It was also noted that the Committee will be presented with the findings from the pilot of the proposed expanded register at the June 2016 Committee where this can be discussed again and decision made about how to progress indicators in this area.

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	Action: NICE to work with the expert advisers from the NICE CKD guideline concerning the benefit of early intervention and feedback to the Committee in June 2016.
11. Exception reporting	MM advised the Committee that NICE had received a letter from the RCGP standing group on over diagnosis, suggesting a need for NICE guidelines to be explicit about the need for clinical judgement by healthcare professionals and informed decision making by patients. The RCGP's letter also suggested that QOF exception reporting codes, and the language to describe them, should be reviewed to incorporate risk-benefit considerations in clinical judgement and patient consent, as opposed to using terms such as 'patient refusal'. The Committee agreed that patient decision making needs to be at the heart of care and that if looking at the current language of QOF exception coding can help this, then this is a good thing. It was though noted that QOF codes are just data sets and that this would perhaps be a small contribution to supporting a broader culture of shared decision making. It was agreed that IAC members would be invited to volunteer to be part of a subgroup that would work with the NICE team, representatives from the RCGP and other stakeholders to take this work forward. The outcome of any work will be fed back to the IAC at a future meeting. **Action**: NICE to set up a sub group based on volunteers from the Committee, to take forward suggestions made on current exception reporting codes.
12. AOB. summary of agreed actions and close of the meeting	DK expressed thanks to Laura Hobbs and Karen Slade who will be leaving NICE for all their work and contribution and congratulated them both on behalf of the Committee. DK summarised the meeting and described how the Committee had looked at relevant sections of pathways in a meaningful way. DK commented how the Committee plans to utilise this approach in the future as well as introducing the concept of quality improvement indicators. DK thanked everyone for attending, confirmed that a number of actions had been agreed for NICE, NCCID and HSCIC to take forward and report back to future meetings. DK then formally brought the meeting to a close.

Summary of actions table

ID number	Action / Recommendation	Lead	Progress
Learning disabilities and Autism			
12.15.01	The Committee agreed that in the first instance a register of people with autism could be investigated by NICE and the NCCID, consulting with a broad range of community based autism groups to request feedback about any issues associated with being included on the GP register. Feedback on this will be brought back to the Committee at a future meeting.	NICE/NCCID	This is due to be piloted in 2016/17 and will go out to consultation in 2016
12.15.02	The committee agreed that an indicator concerning health checks for people with a learning disability should be further investigated and potentially piloted. And that once feedback is received about the proposed general practice register of people with autism that an indicator concerning a health check at diagnosis is considered.	NCCID	The outcome from this action will be presented at the June IAC
12.15.03	Indicator/s looking at admissions to general hospital and mental health services to be consulted upon and tested by NICE and HSCIC	NICE/HSCIC	Outcome from this action will be presented at the June IAC
Heavy menstrual bleeding			
12.15.04	It was agreed that NICE would work with HSCIC to assess whether a CCG level indicator would be feasible looking at rates of different interventions linked to HMB and to also investigate the potential of patient satisfaction / patient reported outcomes indicators in this area.	NICE/HSCIC	HSCIC will present an update on this at the April IAC
Depression			
12.15.05	DK summarised, asking the NICE and HSCIC to further investigate developing potential indicators in this area, looking at treatment options, the number of people being referred and then accessing treatment. Service user/patient reported outcome indicators to be considered	NICE/HSCIC	HSCIC will present an update on this at the April IAC

	also.		
Dementia			
12.15.06	HSCIC and NICE to review current data sets and work with a Committee subgroup to consider potential indicators in this area and bring this back to a future Committee meeting.	NICE/HSCIC	This will be brought to a future meeting for discussion
Breast cancer			
12.15.07	NICE / HSCIC to look at the National Cancer Patient Experience Survey to identify potential indicators the survey could support.	NICE/HSCIC	HSCIC will present an update on this at the next meeting
Antenatal care			
12.15.08	NICE to take the proposed indicator concerning booking by 10 weeks forward with the HSCIC for testing.	NICE/HSCIC	The outcome from this action will be presented at the June IAC
Venous thromboembolism			
12.15.09	HSCIC to review number of deaths from VTE using the agreed ICD-10 codes. Further work also to be done on clarifying the intent of the indicator, that is, should this be based on hospital deaths excluding cases from the community.	HSCIC	HSCIC will present initial findings at the April IAC.
Atrial Fibrillation			
12.15.10	NICE/NCCID to develop indicators for general practice quality improvement focused on the following area: - The proportion of people over 65 with co-morbidities (hypertension, diabetes, CKD, PAD, previous stroke or COPD) who have a manual pulse palpation in the previous 12 months	NICE/NCCID	The outcomes from these action will be presented at the June IAC

	- The proportion of people over 65 who have a manual pulse palpation.		
12.15.11	NICE and the NCCID to develop and pilot an indicator for incentivisation focused on – the proportion of people with atrial fibrillation who are prescribed anticoagulation who discuss the options with their healthcare professional annually.	NICE/NCCID	The outcome from this action will be presented at the June IAC
12.15.12	HSCIC and NICE to develop and test an outcome measure focused on stroke rates in people with AF, potentially split by type of stroke.	NICE/HSCIC	The outcome from this action will be presented at the June IAC
12.15.13	NICE to work with the NCCID to further explore the use of the AF resolved code and report back to the Committee**.**	NICE/NCCID	A decision was made to retain the code, with additional information added to the national QOF guidance to explain the potential ongoing risk for people who have had AF symptoms
Diabetes in children and young people			
12.15.14	NICE and HSCIC to test and consult on indicators concerning the individual diabetes care processes for children and young people.	NICE/HSCIC	The outcome from this action will be presented at the June IAC
Diabetes in pregnancy			
12.15.15	NICE to look into highlighting NICE indicator NM70 to NHS England as a useful indicator to facilitate awareness amongst women with diabetes about pre and post conception care.	NICE	NICE will do this when forwarding the next update to the NICE menu to NHS England in August

12.15.16	HSCIC to review the pregnancy dataset to help inform discussions about feasibility of indicators in this area	AR	Ongoing
12.15.17	NCCID to look at the potential of constructing an indicator for piloting, which considers prevalence diabetes in pregnancy at practice level and a larger population for CCG.	RFT	Ongoing
12.15.18	NICE to find out whether NHS England's work on PROMs will support the development of metrics for diabetes outcome indicators relating to patient experience.	NICE	The outcome from this action will be presented at a future IAC
12.15.19	NICE to look at which outcomes are measurable and report back to Committee.	NICE	The outcome from this action will be presented at a future IAC
Chronic Kidney Disease			
12.15.20	NICE to work with the expert advisers from the NICE CKD guideline concerning the benefit of early intervention and feedback to the Committee in June 2016.	NICE	The outcome from this action will be presented at the June IAC
Exception codes			
12.15.21	NICE to set up a sub group based on volunteers from the Committee, to take forward suggestions made on current exception reporting codes.	NICE	This work has been paused due to the transition to SNOMED. The IAC will be updated as this progresses.