# National Institute for Health and Care Excellence

### Indicator Advisory Committee meeting minutes

**Date:** 8 March 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), Dominic Horne (DH), Rachel Brown (RB), Kate Francis (KF), Chris Wilkinson (CW), Mieke Van Hemelrijck (MVH)

**NICE attendees:**

Craig Grime (CDG), Rick Keen (RK) [minutes], Mark Minchin (MM), Theresa Jennison (TJ), Charlotte Fairclough (CF), Nicola Greenway (NG)

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

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

**NHS Digital:**

Laura Corbett (LC)

**Apologies:**

Tessa Lewis, Raju Reddy, Chris Gale, Andrea Brown

**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 welcomed Chris Wilkinson and Mieke Van Hemelrijck to the committee.

**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:

* LP noted a change of organisation from NHS X to NHS England and Improvement regarding her patient public voice partner role.

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

TJ informed the committee that all actions from the last indicator meeting in September 2021 had been progressed. It was noted that the action regarding the hip screening indicator involving circulation of documentation with a request for feedback had been completed. It was concluded that with no negative feedback received, the indicator had progressed for publication.

The September 2021 minutes were approved as an accurate record.

**Item 4 – NICE and indicator programme update**

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

**Item 5 - Indicators in piloting 2021/22 update**

**Chronic kidney disease (CKD)**

CF presented four indicators on chronic kidney disease that are currently in a pilot stage prior to consultation in March/April 2022:

1. The percentage of patients (excluding those on the CKD register) prescribed long-term (chronic) oral non-steroidal anti-inflammatory drugs (NSAIDs) who have had an eGFR measurement in the preceding 12 months.
2. The percentage of patients with a new diagnosis of CKD stage G3a-G5 (on the register, within the preceding 12 months) who had 2 separate eGFR tests undertaken prior to diagnosis being confirmed, with at least 90 days between tests and the second test no later than 90 days before the diagnosis was recorded.
3. The percentage of patients with a new diagnosis of CKD stage G3a-G5 (on the register, within the preceding 12 months) who had eGFR and ACR (urine albumin to creatinine ratio) measurements recorded 90 days before or after diagnosis.
4. The percentage of patients with CKD on the register and with an ACR of less than 70mg/mmol, without moderate or severe frailty, in whom the last blood pressure reading (measured in the preceding 12 months) is less than 140/90mmHg.

The committee questioned what the evidence base was for monitoring eGFR for patients on long-term NSAIDs. CF noted that it was based on recommendations in the NICE guideline for CKD about monitoring potentially nephrotoxic drugs.

The committee considered that a clear definition of ‘long-term’ was required regarding the first indicator. CF noted that the current definition is 12 prescriptions in 24 months and that it is currently being explored during piloting and through work by the NCCID analysing NHS BSA prescribing data.

CF informed the committee of a proposal for an indicator on the use of dapagliflozin for treating CKD in adults based on a new NICE technology appraisal, that had not been included in the piloting. The committee were asked to consider if it was appropriate to develop this indicator at this time, and if it would be within the remit of general practice by the time of its suggested implementation in April 2023.

The committee noted there is evidence on improving cardiovascular outcomes with this drug but that it is too early to tell if / when it will fall within the remit of general practice. It was suggested that it may be preferable for the committee to wait until dapaglifiozin has been included in the relevant NICE clinical guideline. It was noted that increasing use of first line treatment with angiotensin-converting enzymes (ACEs) or angiotensin-receptor blockers (ARBs) may be a preferable initial priority for quality improvement.   
   
It was suggested that it was highly likely that prescribing rates for this drug will increase over time. It was noted that progressing an indicator on it now would be getting ahead of the curve.

The committee highlighted that while prescription of dapagliflozin in people with CKD is not currently generally within the remit of primary care, it may be very soon. It was suggested that the development of an indicator in this area should be kept on the radar of the committee until there is clearer evidence of uptake of dapagliflozin in people with CKD without type 2 diabetes.

**ACTION: NICE team to progress all four proposed CKD indicators for consultation. Indicator on the use of dapagliflozin to be brought before the committee at a later date**

**Lipid management**

CDG presented four indicators on lipid management that are currently in a pilot stage prior to consultation in March/April 2022:

1. The percentage of patients with cardiovascular disease (CVD) risk assessment score of greater than or equal to 20 percent identified in the preceding 12 months who are offered advice and support for smoking cessation, safe alcohol consumption, healthy diet and exercise within 3 months of the score being recorded.
2. The percentage of patients with a CVD risk assessment score of greater than or equal to 20 percent who are currently treated with a lipid modifying therapy.
3. The percentage of patients with existing CVD who are currently treated with a lipid modifying therapy.
4. The percentage of patients with existing CKD who are currently treated with a lipid modifying therapy.

CDG highlighted that the primary prevention indicators focus on a population with a CVD risk of 20 percent or more, while the NICE guideline recommends primary prevention for people with a CVD risk of 10 percent or more. The rationale was to focus on those with the greatest need for lipid management and address concerns around the workload implications of a denominator using 10% or more.

RB noted that the primary prevention indicators would not promote increased CVD risk assessment in people who had not had a CVD risk assessment. AB noted that, while this is the case, this was not the purpose of the indicator. PW confirmed the contextual searches being undertaken as part of piloting would examine the numbers of people who have their CVD risk assessed.

The committee highlighted concerns with focusing on a population with a CVD risk of 20 percent or more which may be seen as contradicting NICE guidance. PW confirmed the contextual searches being undertaken as part of piloting would examine the numbers of people who have a CVD risk of both 10 percent or more and 20 percent or more.

**ACTION: NICE team to progress all four proposed lipid management indicators for consultation adding separate primary prevention indicators on people with a CVD risk of 10 percent or more.**

CDG highlighted previous committee discussion on the feasibility of indicators focused on the reduction of non-HDL cholesterol. CDG explained that these had not progressed to piloting, instead it had been agreed within NICE that the update to the guideline should be prioritised and is now scheduled to publish April 2023.

**Epilepsy**

CDG presented three indicators on epilepsy that are currently in a pilot stage prior to consultation in March/April 2022:

1. The percentage of adults receiving drug treatment for epilepsy who had a structured review in the preceding 12 months.
2. The percentage of adults with epilepsy and a learning disability who had a structured review in the preceding 12 months.
3. The percentage of adults with epilepsy and a mental health condition who had a structured review in the preceding 12 months.

CDG highlighted a misalignment between the first indicator and the NICE epilepsy guidance that is currently being updated. The draft guidance does not recommend annual review for all people receiving anti-seizure medication, just those receiving treatment that is associated with side effects or potential drug interactions. The NICE team are currently clarifying the specific list of drugs that would mean people would not require annual review in the absence of other factors.

LC asked whether the definition of ‘mental health condition’ for indicator 3 is the same as that used for the QOF mental health register (MH001). CDG confirmed that they match.

**ACTION: NICE team to progress all three indicators on epilepsy for consultation**.

**Item 6 – Assuring external indicators – National Library of quality indicators**

PC presented the methodology which had been adopted for review of 5 indicators due for renewal, 10 indicators due for provisional renewal, and 5 indicators to be discontinued. The process was based on the NICE indicator process guide.

It was noted this is the first occasion of a recommendation to ‘provisionally renew’ indicators. It was revealed that this outcome had been proposed as the appropriate action where either:

* Assessment identifies issues with the validity of the indicator, but the issue(s) can be resolved/addressed if appropriate actions are taken by the framework owner.
* The indicator data is no longer published, and NHS Digital have advised that “no active development” is ongoing, although the assessment criteria have otherwise been met.
* An indicator’s validity is currently under active review elsewhere which may impact the conclusion in the near future.

**ACTION: The committee approved all of NCCID’s recommendations noting disappointment with the removal of quality-of-life indicators. Committee chair to write to the data source owner about this and NICE to discuss with NHS England. NICE team to explore pulling data from other areas such as the Office of National Statistics (ONS) regarding the discontinued indicators.**

**Item 7 – Blood pressure indicators**

CDG presented to the committee three discussion points regarding blood pressure indicators.

Discussion point 1: Misalignment between NICE guidance and QOF indicators on blood pressure management in people with existing CVD: Nine indicators for people with existing CVD use blood pressure targets of: 140/90mmHg or less for people 79 years or under, and 150/90mmHg or less for people 80 years or over.

The committee were asked if the indicators should be changed to use ‘less than’ targets or retained but with an explanation for the misalignment included.

It was noted that the business rules would need to be changed. It was highlighted that for sake of internal consistency and credibility of the QOF it would be better for the indicators to be aligned with the NICE guidance.

**ACTION: NICE team to amend the NICE indicators on blood pressure management to use ‘less than’ targets in line with NICE guidance.**

Discussion point 2: Blood pressure targets and the use of home blood pressure monitoring (HBPM) and ambulatory blood pressure monitoring (ABPM). Nine indicators for people with existing CVD use blood pressure targets of: 140/90mmHg or less for people 79 years or under, and 150/90mmHg or less for people 80 years or over.

CDG noted that these targets match NICE guidance for clinic settings but HBPM is increasing in use so there is a risk undertreatment for certain patients. It was noted that the current QOF business rules do not apply the lower targets when HBPM or ABPM codes are found.   
  
The committee were asked to advise on the need to amend existing indicators to reflect tighter targets for HBPM and ABPM.

LC highlighted that there are already code clusters available for both HBPM and ABPM and that tighter targets can be applied depending on what type of blood pressure monitoring is used.

The committee queried if practices could use readings provided by community pharmacies. It was noted that it would account as an additional data source. It was revealed that this would not be an issue as this data would go to primary care to be entered providing it was coded properly.

The committee agreed that there is increasing use of HBPM and that it supports the NHS policy drive to put patients more in charge of their own health. It was noted that it presents challenges in that practices are relying on new non-practice data sources that were not available before. It was highlighted that there may be a disparity in proper calibration of the HBPM equipment used, especially if it is purchased outside of clinical sources.

The committee agreed that this is an important area for indicator development but that the specifics on data sources and rulesets need to quantified. It was suggested that a working group involving primary care and cardiology colleagues be established.

**ACTION: NICE team to use the upcoming consultation to gather feedback on the proposal to amend indicators to reflect tighter targets for HBPM and ABPM. A working group will be formed with some IAC colleagues to establish the details of the indicator data sources and rulesets.**

Discussion point 3: Misalignment between NICE guidance and NICE indicator NM159 which is included in the QOF (DM019); the indicator uses a single target of 140/80 mmHg or less for people with type 1 or type 2 diabetes without moderate or severe frailty whilst NICE guidance recommended different targets depending on type of diabetes and age.

CDG noted that the existing target does not match NICE targets for either type 1 or type 2 diabetes. The committee were asked if the blood pressure target should be amended, potentially to the type 2 target of 140/90 mmHg. The committee were also asked to consider splitting the indicators between type 1 and type 2.

The committee agreed that there needs to be consistency with NICE guidance. Whilst NICE guidance does not include a single target applicable to both type 1 and type 2 diabetes, using a target of 140/90 mmHg would match guidance for type 2 diabetes and provide an ‘audit target’ for people with type 1 diabetes.

The committee queried whether the indicators should be limited to certain age groups. CDG noted that the current indicators do not reference age and instead use frailty status to determine inclusion.

The committee suggested having an indicator covering all types of diabetes and separate indicators for type 1 and type 2 specifically.

**ACTION: NICE team to amend indicator NM159 to use a target of 140/90 mmHg and develop new indicators for type 1 and type 2 diabetes separately that continue to exclude people with moderate or severe frailty. All indicators will proceed to consultation.**

**Item 8 – Exploration of new topics for potential indicator development**

Social prescribing

JG presented to the committee a discussion paper describing social prescribing and the opportunities to develop relevant stretch indicators for long term conditions using diabetes as an illustrative example. It was revealed that social prescribing is a national priority with promising but limited evidence for reducing demand in acute and primary care, whilst helping improve health and wellbeing and reducing inequalities. It was noted that it may be especially valuable to those living with long term conditions, who are isolated, who have mental health problems, or who have complex social needs. It was highlighted that while there is the potential for new indicators in this area, there are drawbacks such as: a still developing evidence base, identifying high risk populations, population size, and the potential for unintended consequences

The committee were asked to consider if there are opportunities to develop indicators related to social prescribing and how NICE should address the potential drawbacks.

There was an extensive discussion, with many committee members expressing support for the benefits of social prescribing, but also concerns about indicators focusing only on long term conditions and the possibility of introducing additional inequalities. The committee emphasised the potential for the most value being for extremely socially vulnerable groups including the homeless. The committee noted that there is a risk of codifying social prescribing and that it is not necessarily about having a medical model. It was queried if these indicators would lead to coding of all interactions that are not referrals. Questions were raised as to what exactly is being measured and what is the target population.

The committee highlighted concerns that such indicators may increase inequality as only patients likely to engage will be offered the care, with those unable to being lost to services. It was noted that monitoring referral rates could become a number counting exercise that could further increase inequality.

**ACTION: NICE team and NCCID to log social prescribing as a longer-term piece of work.**

Autism

PW presented to the committee an exploration of the opportunity for development of new intervention primary care indicators on autism based on updated NICE guidance CG142 and CG170. It was noted that the guidance, while not explicit about this, could potentially support an annual check particularly around a designated professional, ‘do not do’ medication recommendations and transition-related assessments. It was highlighted that issues were raised during piloting of the existing NICE menu register indicator (NM153) including whether there was access to the relevant services, and what the patient perspective was. The committee was made aware of an NHS England-funded trial of primary care health checks for autistic adults, the outcome of which will be due in Autumn 2023. It was noted that said trial is piloting the primary care health checks.

The committee were asked to consider waiting for the outcome of the NHS England trial before deciding if there was merit to explore developing indicators of primary care health checks for autistic adults.

The committee noted that there were concerns in previous discussions on how autism was categorised on the register. It was queried if people with autism wanted to be on a register and what they perceived their needs were.

The committee queried which health outcomes were worse for people with autism. MM clarified that it was premature mortality and there is evidence available supporting this.

**ACTION: NICE team and NCCID to await the outcome of the NHS England funded trial in Autumn 2023.**

**Item 9 – Indicator updates**

Composite serious mental illness (SMI) indicator

CDG informed the committee that at the September 2021 IAC, a proposal was made for a composite indicator on health checks with people with SMI:

*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 noted that the committee was concerned that the presence of a single ‘personalised care adjustment’ would remove a patient entirely 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. These concerns were discussed with NHS Digital who advised that a single ‘personalised care adjustment’ would remove a patient from the entire denominator and as such, the indicator was not progressed.

Revisiting IND2019-79 – Annual review for people prescribed a long-term antidepressant

CDG highlighted a previously agreed indicator on medication reviews for people on long-term antidepressants. Final quality assurance raised concerns around the CPRD data that was used to test the definition and publication of the indicator was paused. Around half of the records of antidepressant prescriptions had not migrated into the CPRD database. It was noted that was a NICE error, not CRPD.

The revised analysis does not support the previously agreed decision to use the ’12 antidepressants prescriptions in 24 months’ definition as the definition of ‘long-term’. Over 25 percent of people classed as receiving long-term antidepressants by using ‘12 antidepressants in 24 months’ did not have a prescription in every 90-day period. In the original analysis this was around 13 percent. CDG raised concerns about the workload related to an indicator definition that used the ‘prescription in every 90-day period’ definition. PW noted that the new numbers account for approximately 5 percent at practice level compared with diabetes registers running at approximately 7 percent and overall depression practice prevalence at 12 percent.

As per the revised analysis, the committee were asked to consider amending the definition of long-term antidepressant to ‘any antidepressant, every 90-day period for the prior 24 months’ and publishing the indicator as ‘suitable for use outside of the QOF’ because of workload implications.

PW noted that the ‘every 90-day period’ was the original definition of long-term antidepressants that was agreed by the previous IAC, as the strongest available in previous IAC discussions based on discussions with CCG pharmacists The ’12 in 12 months’ definition was also agreed based on the initial analysis that appeared to demonstrate comparability. It had been agreed that either definition could be used, depending on feasibility as advised by NHS Digital (with the assumption being that the ’12 in 12 months’ would be easier to apply).

The importance of this indicator as part of the QOF was re-empathised given the advocacy of expert advice. The committee agreed that if this is targeting the correct group of patients then the workload limitations should not be a reason to prevent progression of the indicator as suitable for use in the QOF. It was noted that general practices have large primary care teams now that could support delivery of reviews.

The committee agreed that the main issue surrounded feasibility of using GPES to extract data using a definition of ‘any antidepressant, every 90-day period for the prior 24 months’. CDG explained that initial advice from NHS Digital is suggesting that extraction from GPES is feasible and he clarified that a ruleset already exists that would need to be rewritten by NHS Digital.

**ACTION: NICE team to liaise with NHS Digital to review the business rules for the IND-2019-79. Subject to review of the revised business rules by NICE, the committee recommended publishing the revised indicator as suitable for use in QOF.**

**Item 10 - Review of decisions**

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

**AOB**

The committee gave a farewell to Theresa Jennison and Paula Whitty who will both be retiring before the next IAC committee meeting. The committee and NICE both formally thanked Theresa and Paula for the huge contribution they had made.

LP recommended an approach of using a brief summary explanation of each indicator and what their intended objective is prior to the committee discussion on them.

KF raised a query about the Improvement and Investment Fund (IIF). It was noted that it lends itself to the same evidence-base that is applied for NICE indicators. It was queried as to whether IIF indicators would in the future be assessed and or developed through the NICE process. MM clarified that NHS England develop their own indicators for the IIF and that NICE has no formal role in that process with no indication of that changing.

**Close of meeting**