# UNIVERSITY OF BIRMINGHAM AND UNIVERSITY OF YORK HEALTH ECONOMICS CONSORTIUM (NICE EXTERNAL CONTRACTOR)

## Development feedback report on piloted indicator(s)

**QOF indicator area:** Cancer

**Pilot period:** 1st April – 30th September 2011

**Potential output:** Recommendations for NICE menu

## Contents

# Background

As part of the NICE-managed Quality and Outcomes Framework (QOF) process, all clinical and health improvement indicators are piloted, using agreed methodology, in a representative sample of GP practices across England, Scotland, Wales and Northern Ireland.

The aim of piloting is to test whether indicators work in practice, have any unintended consequences and are fit for purpose.

# Piloted indicators

1. The percentage of patients with cancer diagnosed within the preceding 18 months who have had a review recorded as occurring within 3 months of the practice receiving confirmation of the diagnosis.
2. The percentage of patients with recurrent or distant metastatic cancer diagnosed within the preceding 18 months who have a review recorded as occurring within 3 months of the practice receiving confirmation of the diagnosis.

| | |
|---|---|
| Number of practices participating in the pilot: | 31 |
| Number of practices withdrawing from the pilot: | 2 |
| Number of practices where staff were interviewed: | 31 |

(24 GPs, 3 PNs, 2 PMs, 1 data manager and 2 group interviews (1 x GP, PN, PM and 1 x GP and PM))

# Assessment of clarity, reliability, acceptability, feasibility, and implementation

## *Clarity*

- Indicator wordings as stated, rated as clear and unambiguous by the consensus Rand panel.

- The NHS IC has confirmed that they have been able to write Business Rules (and/or an Extraction Specification)**.**

## *Reliability[1] and Feasibility*

| Indicator | Feasibility | Reliability | Implementation |
|---|---|---|---|
| **1** | 3 | 3 | 3 |
| **2** | 3 | 3 | 3 |

[1] NHSIC provide guidance on whether the piloted indicators are, from a business rule perspective, suitable to become 'live' indicators. A notional 'scoring' system is used:

1. No problems to implement in live with other indicators
2. Minor re-work before it can go live with other indicators
3. Major re-work but do-able without recourse to anyone outside of the process
4. Major considerations to be made before the indicator can go live - possibly need to speak to CFH / suppliers
5. Not feasible

| Comments | Response | NHSIC Summary |
|---|---|---|
| Will require two new cancer registers, one for primary cancer and one for recurrent or distant metastatic cancer. | It has been decided that the cancer clusters will be separated so there will be one for primary cancer and one for recurrent or distant metastatic malignancies.<br><br>This would make indicator 1 apply to primary cancer only and indicator 2 apply to recurrent or distant metastatic malignancies only.<br><br>So if a patient has a first or new primary cancer episode in the last 15 months then they require a review 3 months after diagnosis and this is checked in indicator 1.<br>If this same patient gets a first or new diagnosis of metastasis or recurrence after the primary cancer they will also need to have a review after this and this will be checked in indicator 2. | Assume that the two new indicators would replace the current CANCER 3 indicator so the current live cancer register would be replaced by two new registers.<br><br>This would also impact CANCER 1. |

## *Acceptability*

General comments

There was general agreement that practices should be actively involved with this group of patients.

Acceptability indicator 1

Two fifths of practices felt that this indicator should be included in QOF. Of these practices many were already trying to work to a 3 month review window under the existing Cancer 3 indicator. They felt that there was patient benefit to the practice reviewing them early in their cancer journey and that the existing 6 month window could be too long. Having a shorter window for the review ensured practices were more proactive in contacting patients and offering them support at what was often a difficult time.

Approximately a third of practices felt that the timescale for the review should not be shortened to 3 months with remaining practices expressing some ambivalence about the timescale and expressed doubts that a 3 month review was appropriate for all patients. Where practices did not think that the timescale should be shortened this was primarily because they felt that patients were already busy enough during this period with ongoing secondary care treatment. Concern was also expressed that they may be trying to perform a review with limited information about the patient's treatment plan and prognosis. These less positive practices also noted that under the existing Cancer 3 indicator, there was no reason why patients could not be reviewed earlier than 6 months where clinically appropriate. As baseline achievement for this indicator shows, approximately two thirds of cancer reviews in live QOF are already occurring within 3 months of the diagnosis.

Practices also felt that consideration needed to be given to the acceptability of telephone reviews for this indicator as they didn't want to see patients 'dragged into the surgery' just so the GP could tick a QOF box. It was also felt that the content of the review should not be too tightly specified to ensure that any contact could be tailored to the needs of the individual patient.

Acceptability indicator 2

Most practices felt that maintaining contact with this patient group was a good thing for general practice to be doing even if they didn't think the indicator itself should go into QOF. Two fifths of practices felt that this indicator should go into QOF. These practices noted that although they were probably seeing this group of patients anyway, this indicator was worthwhile in that it was useful for awareness raising and for ensuring proactive patient contact and enabling offers of support.

45% of practices did not think this indicator should be included in QOF. The main reasons for this were problems with specifying the content of the review and definitional and recording issues in relation to recurrence and metastatic disease.

The remaining small number of practices were ambivalent about the indicator.

Most practices felt that the content of the review would need to be very loosely specified in order to reflect the variable nature of cancer as a condition, resulting in variable requirements for variable support. Many of these patients are being actively treated for their recurrent disease in which case it might be inappropriate if the review were to focus more on palliative care issues. One practice interpreted the spirit of this indicator as being about making contact with the patient rather than them needing to come into the practice for a consultation which follows a set pattern. Another GP noted that he thought this was more about pastoral care than a treatment discussion. This variability in review content raises the potential for gaming and differential practice performance which is difficult to monitor and challenge. One GP commented that this indicator risked introducing too much box-ticking into cancer care without thinking about whether it is the right thing for the patient at that time.

The potential overlap with the palliative care indicator was also noted.

Many practices reported problems with recording recurrent and metastatic disease. It was felt that the definition of these terms was open to interpretation and that recording a patient with, for example, lung cancer to lung cancer with metastases may not have any patient benefit. Other practices raised the issue of when does the original cancer diagnosis become 'resolved' so that a recurrence can be recorded as such rather than it being a continuation of the original problem.

<u>Acceptability recommendation indicator 1</u>

- There are barriers/ risks/ issues/ uncertainties identified from the pilot *in terms of acceptability* that in themselves may not be sufficient to prevent an indicator being recommended by the AC, but require the particular attention of the AC.

<u>Acceptability recommendation indicator 2</u>

- There are barriers/ risks/ issues/ uncertainties identified from the pilot *in terms of acceptability* that in themselves may not be sufficient to prevent an indicator being recommended by the AC, but require the particular attention of the AC.

## *Implementation*

### Assessment of piloting achievement

1. The percentage of patients with cancer diagnosed within the preceding 18 months who have a review recorded as occurring within 3 months of the practice receiving confirmation of the diagnosis.

| **CANCER INDICATOR 1** | Baseline | Final |
|---|---|---|
| Number of Practices Uploading | **11** | **11** |
| Practice Population | **87,529** | **87,989** |
| | | |
| Cancer Register 1 | **164** | **93** |
| **Excluded regardless of whether they meet Numerator criteria** | *less* | *less* |
| Primary Cancer Diagnosis more than 15 months ago | 0 | 0 |
| **Excluded if they do not meet Numerator criteria** | | |
| Primary Cancer Diagnosis within last 3 months and no review | 25 | 21 |
| Cancer Review more than 12 months ago | 0 | 0 |
| Registered in last 3 months | 0 | 0 |
| Cancer Exclusion within last 15 months | 0 | 0 |
| Primary Cancer Diagnosis within last 3 months | 0 | 0 |
| **Total Exclusions** | **25** | **21** |
| | *equals* | *equals* |
| Cancer Indicator 1 Denominator | **139** | **72** |
| Cancer Indicator 1 Numerator | **87** | **46** |
| Numerator as % of Denominator | **62.59%** | **63.89%** |

## *Assessment of piloting achievement*

2. The percentage of patients with recurrent or distant metastatic cancer diagnosed within the preceding 18 months who have a review recorded as occuring within 3 months of the practice receiving confirmation of the diagnosis.

| **CANCER INDICATOR 2** | Baseline | Final |
|---|---|---|
| Number of Practices Uploading | **1** | **1** |
| Practice Population | **17,054** | **17,088** |
| | | |
| Cancer Register 2 | **7** | **5** |
| **Excluded regardless of whether they meet Numerator criteria** | *less* | *less* |
| Recurrent/Metastatic Cancer Diagnosis more than 15 months ago | 0 | 0 |
| **Excluded if they do not meet Numerator criteria** | | |
| Recurrent/Metastatic Cancer Diagnosis within last 3 months and no review | 4 | 3 |
| Cancer Review more than 12 months ago | 0 | 0 |
| Registered within last 3 months | 0 | 0 |
| Cancer Exclusion within last 15 months | 0 | 0 |
| Recurrent/Metastatic Cancer Diagnosis within last 3 months | 0 | 0 |
| **Total Exclusions** | **4** | **3** |
| | *equals* | *equals* |
| Cancer Indicator 2 Denominator | **3** | **2** |
| Cancer Indicator 2 Numerator | **1** | **1** |
| Numerator as % of Denominator | **33.33%** | **50.00%** |

Please note the final audit looked back 6 months.

Summary

- Practices were divided as to whether the existing QOF indicator (Cancer 3) should be amended. Those who were supportive of this change felt that it was important for general practice to be involved with patients early in their cancer journey. Those who were not supportive felt that patients were busy with secondary care and treatment during this time and that a 3 month review was not clinically appropriate for all patients.
- Practices with concerns about shortening the review timeframe for the existing Cancer 3 to 3 months noted that there was no reason why reviews could not currently take place within this time where clinically appropriate. Analysis of baseline achievement demonstrated that approximately two-thirds of reviews are currently undertaken within 3 months.
- Whilst the majority of practices were supportive of the principle of reviewing patients with recurrent disease they expressed concerns in relation to the accurate recording of recurrent and metastatic disease and specifying the content of the review in the detail required for QOF and QOF assessment.
- Some practices felt that both these reviews should be either face-to-face or over the telephone and the content should not be tightly specified so that they could be tailored to individual circumstances.

**Changes in practice organisation**

General comments

Practices tended to use the existing Cancer 3 templates for both the 3 month review after initial diagnosis and for any review following identification of recurrent or metastatic disease.

Specific comments indicator 1

A small number of practices commented that they currently struggle to get reviews completed in 6 months.

Specific comments indicator 2

This would require new call and recall systems to ensure all patients identified. New templates may also be required depending upon how the content of the review is specified.

**Resource utilisation and costs**

General comments

None.

Specific comments indicator 1

Most practices felt that there was limited additional workload associated with this indicator as cancer reviews needed to be completed anyway as part of QOF: the only difference was the timescale. However, two practices reported that they struggled to get the reviews completed within 3 months.

Specific comments indicator 2

Most practices felt that this did not result in much extra work due to the small numbers of patients affected and that they are probably seeing most of these patients as part of routine care.

**Barriers to implementation**

General comments

None.

Specific comments indicator 1

None.

Specific comments indicator 2

Practices reported difficulties in identifying and recording recurrent and metastatic disease.

**Assessment of exception reporting**

Specific comments indicator 1

It was noted that a 3 month review was not clinically appropriate for all patients which may result in increased levels of exception reporting when compared to the current Cancer 3 (ER= 1.3% in 2010/11).

**Assessment of potential unintended consequences**

Specific comments indicator 1

Concerns were expressed about the applicability of a 3 month review for all patients with a new diagnosis of cancer. Concerns were expressed that this may result in

patients being repeatedly asked to attend the surgery as practices 'chased points' or in GPs cold calling to tick the QOF box.

Specific comments indicator 2

Concerns were expressed about the variable prognosis of recurrent and metastatic disease, variable patient treatment options and need for support and how this would be translated into the components of any review. It was noted that it cannot be assumed that all these patients will progress to palliative care.

Implementation recommendation indicator 1

- There are barriers/ risks/ issues/ uncertainties identified from the pilot *in terms of implementation* that in themselves may not be sufficient to prevent an indicator being recommended by the AC, but require the particular attention of the AC.

Implementation recommendation indicator 2

- There are barriers/ risks/ issues/ uncertainties identified from the pilot *in terms of implementation* that in themselves may not be sufficient to prevent an indicator being recommended by the AC, but require the particular attention of the AC.

## Assessment of overlap with existing QOF indicators and potential changes to existing QOF indicators

These indicators overlap with the existing CANCER3 and Palliative Care 2.

*CANCER3: The percentage of patients with cancer, diagnosed within the preceding 18 months who have had a patient review recorded as occurring within 6 months of the practice receiving confirmation of the diagnosis.*

*PC2: The practice has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative register are discussed.*

## Overall recommendation

Indicator 1

- There are barriers/ risks/ issues/ uncertainties identified from the pilot that in themselves may not be sufficient to prevent an indicator being recommended by the AC, but require the particular attention of the AC.

Indicator 2

- There are barriers/ risks/ issues/ uncertainties identified from the pilot that in themselves may not be sufficient to prevent an indicator being recommended by the AC, but require the particular attention of the AC.

## Suggested amendments to indicator

If a 3 month window for the review period is recommended, the resulting indicators will only need to look back 15 months to ensure that all eligible patients are identified rather than the 18 month window piloted. It is therefore proposed that the indicators are reworded as follows:

1. The percentage of patients with cancer diagnosed within the preceding *15* months who have had a review recorded as occuring within 3 months of the practice receiving confirmation of the diagnosis.
2. The percentage of patients with recurrent or distant metastatic cancer diagnosed within the preceding *15* months who have a review recorded as occuring within 3 months of the practice receiving confirmation of the diagnosis.

# Appendix A: Indicator details

**Recommendation(s) presented and prioritised by the Advisory Committee**

A review cancer 3 was presented to the NICE Advisory Committee on 2 occasions- June and December 2010.In June, the Committee could not reach a consensus on the timeframe and requested further assessment of feasibility. In December, the Committee noted the advice from the IC that one of the proposed changes to the indicator to include metastatic cancer in the indicator was technically problematical and therefore the potential change should be piloted. The Chair noted the lack of evidence base on the most appropriate timeframe.

**The wording for current QOF indicator Cancer 3 is as follows:**

*Cancer 3: The percentage of patients with cancer, diagnosed within the last 18 months who have a patient review recorded as occurring within 6 months of the practice receiving confirmation of the diagnosis*

**Summary of Committee considerations (taken from the December 10 Committee minutes)**

Progress for indicator development. The committee agreed that a clear definition of what is meant by new metastatic cancer would need to be identified as part of indicator development.

**Pre-RAND indicators**

1. The percentage of patients **with cancer** diagnosed within the preceding 18 months who have a review recorded as occurring within 3 months of the practice receiving confirmation of the diagnosis.

2. The percentage of patients with **recurrent or distant metastatic cancer** diagnosed within the preceding 18 months who have a review recorded as occurring within 3 months of the practice receiving confirmation of the diagnosis.

**Considerations from the RAND/UCLA appropriateness method (RAM) panel**

**[Not published if on NICE website]**

**Final indicator as piloted**

1. The percentage of patients with cancer diagnosed within the preceding 18 months who have a review recorded as occurring within 3 months of the practice receiving confirmation of the diagnosis.

2. The percentage of patients with recurrent or distant metastatic cancer diagnosed within the preceding 18 months who have a review recorded as occurring within 3 months of the practice receiving confirmation of the diagnosis.

**NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE**

# QUALITY AND OUTCOMES FRAMEWORK (QOF) INDICATORS EQUALITY IMPACT ASSESSMENT FORM

As outlined in the QOF process manual NICE has a duty to take reasonable action to avoid unlawful discrimination and promote equality of opportunity. The purpose of this form is to document that equality issues have been considered in each stage of indicator development prior to reaching the final output which will be approved by Guidance Executive.

Taking into account **each** of the equality characteristics below the form needs to:

- Confirm that equality issues have been considered at **every stage** of the process (from topic suggestion and scoping, prioritisation, development including consultation and piloting)
- Confirm that equality issues identified in the topic suggestion and scoping stages have been considered in the prioritisation, development stages including consultation and piloting
- Ensure that the recommendations do not discriminate against any of the equality groups
- Highlight planned action relevant to equality
- Highlight areas where recommendations may promote equality

This form is completed by the NICE QOF internal team and the NICE external contractor (NEC) **for each new indicator that is developed at each of the stages ( from topic selection and scoping, prioritisation, development including consultation and piloting, and also in the future for sets of indicators in clinical domains.** The form will be submitted with the final outputs to the Primary Care QOF Indicator Advisory Committee for validation, prior to sign off by NICE Guidance Executive

| **EQUALITY CHARACTERISTICS** |
|---|
| **Sex/gender**<br>• Women<br>• Men |
| **Ethnicity**<br>• Asian or Asian British<br>• Black or black British<br>• People of mixed race<br>• Irish<br>• White British<br>• Chinese<br>• Other minority ethnic groups not listed<br>• Travellers |
| **Disability**<br>• Sensory<br>• Learning disability<br>• Mental health<br>• Cognitive<br>• Mobility<br>• Other impairment |
| **Age**[1]<br>• Older people<br>• Children and young people<br>• Young adults<br><br>1. Definitions of age groups may vary according to policy or other context. |
| **Sexual orientation & gender identity**<br>• Lesbians<br>• Gay men<br>• Bisexual people<br>• Transgender people |
| **Religion and belief** |
| **Socio-economic status**<br><br>Depending on policy or other context, this may cover factors such as social exclusion and deprivation associated with geographical areas (e.g. the Spearhead Group of local authorities and PCTs, neighbourhood renewal fund areas etc) or inequalities or variations associated with other geographical distinctions (e.g. the North/South divide, urban versus rural). |
| **Other categories**[2]<br>• Refugees and asylum seekers<br>• Migrant workers<br>• Looked after children<br>• Homeless people<br><br>2. This list is illustrative rather than comprehensive. |

# QOF INDICATORS EQUALITY IMPACT ASSESSMENT FORM: EACH STAGE OF DEVELOPMENT PROCESS

## Topic title: Cancer
## Development stage: Piloting of indicators

### 1. Have relevant equality issues been identified during this stage of development?

- Please state briefly any relevant issues identified and the plans to tackle them during development

None identified

### 2. If there are exclusions listed in the clinical or health improvement indicator areas (for example, populations, treatments or settings) are these justified?

- Are the reasons legitimate? (they do not discriminate against a particular group)
- Is the exclusion proportionate or is there another approach?

None identified

### 3. Do any of the recommendations make it impossible or unreasonably difficult in practice for a specific group to access a test or intervention?

- Does access to the intervention depend on membership of a specific group?
- Does a test discriminate unlawfully against a group?
- Do people with disabilities find it impossible or unreasonably difficult to receive an intervention?

No

### 4. Have relevant bodies and stakeholders been consulted?

- Have relevant bodies been consulted?
- Have comments from stakeholders that highlight potential for discrimination or promoting equality been considered in the final draft?

Yes by NICE

### 5. Do the indicators promote equality?

Please state if the indicator as described will promote equalities, for example by making access more likely for certain groups, or by tailoring the intervention to certain groups?

Not applicable to this indicator.