

**NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE**

**SPECIAL HEALTH AUTHORITY**

**Primary Care Quality and Outcomes Framework Indicator Advisory  
Committee**

**DRAFT** unconfirmed minutes of the Committee's meeting held at 10:00 on 2 June 2010 at the NICE offices, National Institute for Health and Clinical Excellence, Level 1a, City Tower, Piccadilly Plaza, Manchester, M1 4BD

**In attendance:**

Committee members:

- Dr Colin Hunter (Chair)
- Dr Ann Hoskins
- Dr Bill Taylor
- Dr Keith MacDermott
- Dr Paramjit Gill
- Professor Bruce Guthrie
- Professor Anthony Kendrick
- Dr Stephen Gillam
- Mr Stephen Humphreys
- Mr Graham Pimblett
- Dr Maeve Lambe
- Professor Lewis Ritchie
- Dr John Woodhouse

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Dr Andrew Anderson

Dr Andrew Kilpatrick

Dr Jane Bridger

Dr Lindsay Smith

Dr Nadeem Qureshi

Dr Nicholas Steel

Dr Robert Thompson

Mr David Freedman

Mr Martin Edgerton

Mrs Alison Bowser

Mrs Cath Morris

Mrs Jan Norman

NICE Staff: Val Moore, Implementation Director

Nicola Bent, Associate Director

Daniel Sutcliffe, Programme Manager

Terence Lacey, Technical Advisor

Laura Hobbs, Technical Analyst

Esther Clifford, Project Manager

Helen Crosbie, Co-ordinator

Emma Boileau, Co-ordinator

## Unconfirmed minutes – Day one of the June 2010 QOF Advisory Committee

Fergus Macbeth, Director, Centre for Clinical Practice

Christine Carson, Programme Director, Centre for Clinical Practice

NICE External Contractors (NEC) :

Professor Helen Lester, Professor of Primary Care, National Primary Care Research and Development Centre

Dr Stephen Campbell, Senior Research Fellow, National Primary Care Research and Development Centre

Professor John Hutton, Director, Yorkshire Health Economics Consortium

Martyn Burke, Consultant, Yorkshire Health Economics Consortium

External Technical Adviser (ETA):

Dr Pete Horsfield, Clinical Director, PRIMIS +

Dr Paul Amos, Clinical Coding Specialist, NHS Information Centre for Health and Social Care

Apologies: Professor Liam Smeeth, Dr Richard Quirke, Dr Mark Vaughan, Professor Tim Stokes, Rebecca Lea

### **Minutes by agenda item**

#### **Item 1: Quality and Outcomes Framework (QOF) Indicator Advisory Committee Position Statements**

This item was discussed before the opening of the meeting to the public.

The Committee had previously received position statements in advance of the meeting and were asked to sign off the decision making guidance set.

*Indicators that incentivise referral to other services*

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The Committee agreed the wording of the position statement but asked how this would affect the cost effectiveness analysis process for indicator development. The NICE External Contractor (NEC) stated that this would be taken into account in the analysis.

### *Thresholds and cost effectiveness*

The Committee agreed with the position statement regarding thresholds and cost effectiveness but added that this is an area that directly affects GP practice income and asked if the methodology developed by the NEC would be available in the public domain, as it is a relatively evidence free area. NEC agreed that the methodology used would be published.

### *Retirement of Indicators*

The Committee agreed with the position statement regarding the retirement of indicators.

### *Directed enhanced services*

The Committee agreed with the position statement regarding the Directed Enhanced Services (DES).

### *Topics that relate to screening*

The Committee agreed with the position statement regarding topics that relate to screening.

A Committee member questioned whether health inequalities should be included in the position statements. NICE assured the Committee that the Equality Impact Assessment Form is used at all key development stages.

## **Item 2: Introduction to the meeting and code of conduct for members of the public attending the meeting**

The Chair welcomed all members of the Committee, members of the public and observers present at the meeting.

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The Chair outlined the code of conduct for members of the public and reminded observers they may not contribute directly to the meeting. The Chair announced that certain items on the agenda will require a Part 2 section, in accordance with the Public Order Act of 1960 which states the following:

*Representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.*

Members of the public were reminded that the Committee is independent and advisory and therefore decisions and recommendations may change as a result of public consultation. The Chair noted that it is the QOF negotiators that ultimately decide which of the proposed recommendations will be used within the QOF and the negotiations are conducted between NHS Employers on behalf of the Department of Health, Devolved Administrations and the BMA General Practitioners Committee.

Members of the press were reminded that they should not report on what was said by Committee members, although it was permissible to report on what was said by the Chair.

### **Item 3: Minutes of the last Advisory Committee meeting held on 10<sup>th</sup> December 2010**

The unconfirmed minutes of the December Committee were checked and agreed for accuracy by the Committee.

### **Item 4: Matters arising**

There were no matters arising.

### **Item 5: Any other business**

No other items of business were requested by Committee for discussion.

The Committee were asked for any items which they may wish to bring to day two of the QOF Indicator Advisory Committee meeting on Thursday 3<sup>rd</sup> June 2010.

**Item 6: Structured decision making**

The Chair gave an overview of the decision options that should be used by the Committee in relation to the recommendation of new indicators for publication on the NICE menu of indicators and the review of existing QOF indicators.

*Decision options for potential new indicators for the NICE menu of indicators:*

The Chair confirmed that the following recommended options should be used by the Committee to determine what actions should be taken for developed new indicators:

- Recommend that the indicator is published on the NICE menu of indicators for consideration for the QOF
- Recommend that the indicator is not published on the NICE menu of indicators for consideration for the QOF

*Decision options for review of existing QOF indicators*

The Committee was informed that the review of existing indicators follows the process and criteria outlined in the QOF interim process guide and takes into account criteria including evidence of unintended consequences, significant changes to the evidence base or changes in current practice. The Chair confirmed that the following recommended options should be used by the Committee to determine what actions should be taken for existing QOF indicators:

- Recommend that no action is required
- Recommend for further review of the evidence base

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- Recommend appropriate action to improve effectiveness of the indicator
- Recommend for retirement

### **Item 7: NICE Advisory Body declaration of conflicts of interest**

Professor Anthony Kendrick declared a personal non-pecuniary interest in Depression and Obesity.

Dr Keith Macdermott declared a personal non-pecuniary interest in Myocardial Infarction.

Dr Paramjit Gill declared a personal non-pecuniary interest in Lipid Modification.

Professor Bruce Guthrie declared a personal non-pecuniary interest in measuring quality and Diabetes and Cardiovascular Disease.

Dr Nicholas Steel declared a personal non-pecuniary interest in the effects of the Quality and Outcomes Framework.

Professor Lewis Ritchie declared a personal non-pecuniary interest in Coronary Heart Disease (CHD) and Palliative Care.

Dr Lindsay Smith declared a personal non-pecuniary interest in Osteoporosis.

Dr Nadeem Qureshi declared a personal non-pecuniary interest in the primary care relevance of NICE guidelines

Dr Andrew Anderson declared a personal non-pecuniary interest in Lower Urinary Tract Symptoms (LUTS)

### **Item 8: Consultation, Development and Cost Effectiveness Results on Potential New QOF Indicators for year 2011/12**

#### ***8.2 Asthma***

#### ***NICE Consultation***

The following indicator was the subject of stakeholder consultation by NICE:

*The percentage of patients with asthma who have had an asthma review in the previous 15 months that includes an assessment of asthma control using the 3 RCP questions*

The NICE QOF programme team presented this summary of the briefing report to the Committee.

There was overall agreement from stakeholders with the inclusion of the indicator, in that it would help to standardise current practice and that it could be implemented without any significant barriers or unintended consequences.

Some stakeholders questioned whether different methods of delivering the asthma review should be considered for different patients, namely an option for telephone interviews for step 1 of asthma management.

A stakeholder commented that older people may be more likely to attend an asthma review than younger people and that some black and minority ethnic groups also have poor attendance at review. What happens following review of asthma control was highlighted as crucial, as was importance of following up non-attendees.

### ***NEC development feedback on piloted indicators***

The Committee was presented with the results of the indicator development and pilot feedback for this indicator. The overall recommendation of the NEC was that there were some uncertainties identified from the pilot that in themselves may not be sufficient to prevent an indicator being recommended by the Committee, but require the particular attention of the Committee.

The Committee was informed that the logic within the business rules is that the review and the 3 RCP questions are all recorded on the same day. When a review that included recording the 3 RCP questions has occurred and is followed by a subsequent consultation that is also recorded as a review, but where the 3 RCP questions are not asked, the preceding recording is

overwritten. The Committee was asked to take a decision on whether this is a problem.

The NEC stated that this indicator had the potential to be cost effective since it changes the availability of information available to the treating clinician in a disease where there is a proven therapy.

Cost effectiveness analysis would involve a number of assumptions. The NEC stated that the cost effectiveness of this indicator is currently unclear, but this did not mean that it is poor value for money, but rather that new studies are required to produce the data needed to determine its cost effectiveness.

Threshold analysis suggested that this indicator could be cost effective across a range of points and thresholds.

### **Committee Summary**

An expert technical adviser (ETA) stated that technically the business rules could be amended so that the three RCP questions could occur outside of a review without the risk of a clinician being penalised for not having achieved the indicator.

The Chair declared a part two section in accordance with the Public Order Act of 1960 which states the following:

*Representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.*

The minutes of the part two session are presented below.

The Committee noted that there was a difference between the original recommended indicator and the final indicator that was developed. The NEC stated that the Committee had previously highlighted that the original indicator did not provide a strong evidence base for the inclusion of food allergies and rhinitis in this indicator and that the term 'food allergy' may present challenges in recording against this indicator.

The Committee asked whether the proposed indicator would replace Asthma 6. NICE confirmed that Asthma 6 would be replaced by the new indicator

The Committee asked if it was necessary to state whether the asthma review should be face to face or over the telephone. NEC explained that most of the evidence supported face to face consultations and that the published evidence which supports a non-face to face review may not be generalisable to UK primary care settings.

The Committee discussed whether a telephone consultation was more effective than none at all. The Committee noted that the use of telephone was becoming increasingly common particularly in the care of younger patients and those patients who are harder to engage for review.

The Committee discussed the potential unintended consequences of making a specific recommendation that the consultation should be face to face as, in some cases, a telephone consultation may be appropriate.

The Committee considered that these uncertainties meant that no specific recommendation could be made that the asthma review should occur in face to face settings only. It was considered that clinical judgement should determine whether a specific review was conducted face to face or by telephone.

### **Committee Decisions**

The Committee recommended that this indicator replace Asthma 6 and agreed that it be progressed for inclusion on the NICE menu for consideration for QOF, subject to changes to the business rules by the NHS Information Centre for Health and Social Care (NHS IC) with support from the ETA.

### **8.3 Dementia**

#### ***NICE Consultation***

The following indicator was the subject of stakeholder consultation by NICE:

*The percentage of patients with a new diagnosis of dementia to have FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded 6 months before or after entering on to the register*

The NICE QOF programme team presented this summary of the briefing report to the Committee:

There were a number of general comments made by stakeholders agreeing with the inclusion of the indicator including that the proposed indicator is evidence-based, reflects good practice and that there should be no barriers to implementation.

People who refuse a blood test or are unable to provide a sample would need to be excluded. Exclusions for people who are diagnosed at another practice or in secondary care may need to be made.

Some stakeholders questioned the appropriateness of the 6-month timeframe and whether this was adequate, as diagnosis often takes place over longer periods of time. Conversely, one stakeholder suggested that investigations to exclude reversible causes should be done pre-diagnosis or within a very short period after diagnosis is made.

Sharing of diagnosis information between primary and secondary care was identified as a potential barrier to implementation. Some stakeholders asked whether laboratories would process B12/Folate in the presence of normal FBC, and noted that the risk of malnutrition and nutrition status following diagnosis may not be adequately addressed.

### ***NEC Development feedback on pilot indicators***

The Committee was presented with the results of the indicator development and pilot feedback for this indicator.

The overall recommendation of the NEC was that there are uncertainties identified from the pilot that in themselves may not be sufficient to prevent an

indicator being recommended by the Committee, but require the particular attention of the Committee.

Feedback from the pilot was that there was a high level of acceptability for this indicator, and around 50% of the pilot practices already carry out screening before referral.

Some practices perceived that this indicator could standardise local variation in practice relating to local referral pathways.

The NEC stated that this indicator is not amenable to cost effectiveness analysis modelling. However, this did not mean that it is necessarily cost ineffective.

### ***Committee Summary***

The Chair noted that minor amendments to the wording of the indicator were required in relation to the point at which the patient is entered on to the register and suggested this could be developed by the NHS IC with support from the ETA.

The ETA discussed whether it was necessary to consider the issue of episode management, as highlighted in the pilot feedback. The ETA advised there were challenges in handling conditions that were episodic in nature. However, dementia is not episodic so these difficulties do not apply.

The Committee considered the implications of the diagnosis of dementia being made by a third party, for example in hospital, and that this might be outside the control of general practice. The Committee agreed that this could be managed by exclusions or exception reporting.

The Chair declared a part two section in accordance with the Public Order Act of 1960 which states the following:

*Representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.*

The minutes of the part two session are presented below.

The Committee considered whether longer timescales would be required due to potential low numbers, as some GPs would be unfairly disadvantaged by the 6 month timescale currently recommended.

NEC said the intent of the indicator was to highlight people with a treatable cause of dementia. The Chair said there was evidence to suggest that this screening is not happening at the moment and indicated that the denominator for some practices might be small.

The Committee noted that a start date would be needed for this indicator, in common with other indicators in the QOF.

### **Committee Decisions**

The Committee agreed that a start date is required and suggested inserting “new diagnosis since the 1st of April 2011” into the final indicator wording.

The Committee recommended the indicator is published on the NICE menu of indicators for consideration for the QOF.

### **8.4 Diabetes**

#### ***NICE Consultation***

The following two indicators were the subject of stakeholder consultation by NICE:

- 1. The percentage of patients with diabetes with a record of testing of foot sensation using a 10 g monofilament or vibration (using biothesiometer or calibrated tuning fork), within the preceding 15 months*
- 2. The percentage of patients with diabetes with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin*

*changes or previous ulcer) or 4) ulcerated foot within the preceding 15 months*

The NICE QOF programme team presented this summary of the briefing report to the Committee:

There was overall agreement with the inclusion of the two diabetes indicators, in that they are linked to improved patient outcomes and they support improvements in diabetes related foot-care. Stakeholders commented that the two indicators did not present any significant barriers to implementation, have no unintended consequences and do not have the potential to impact unevenly.

Overall, diabetes indicator 2 (risk assessment) was considered to be a more useful indicator than the existing diabetes QOF indicators (DM 9 and DM 10) for foot assessment as it indicates clinical risk. Some stakeholders suggested that the detail of risk assessment is more appropriate for formal podiatry services and/or that this indicator could lead to potential duplication. However, one stakeholder commented that the indicator could help to direct podiatry resources to those who need them most while having the potential to help protect the most vulnerable.

### ***NEC Development feedback on piloted indicators***

The overall recommendation of the NEC for both indicators was that there is a high degree of confidence that there are no major uncertainties identified from the pilot that would preclude the indicator from being recommended for publication on the NICE menu of indicators.

The NEC stated that this indicator had the potential to be cost effective since it changes the availability of information available to the treating clinician in a disease where there is a proven therapy.

Cost effectiveness analysis would involve a number of assumptions. The NEC stated that the cost-effectiveness of this indicator is currently unclear, but this

did not mean that it is poor value for money, but rather that new studies are required to produce the data needed to determine its cost-effectiveness.

Threshold analysis suggested that this indicator could be cost effective across a range of points and thresholds.

### **Committee Summary**

The Chair declared a part two section in accordance with the Public Order Act of 1960 which states the following:

*Representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.*

The minutes of the part two session are presented below.

The Committee discussed issues relating to where the foot risk assessment takes place and whether this would place a burden on podiatry services. However, the Committee agreed that the question of where risk stratification is performed is a matter for practices to decide and that in many general practices foot risk stratification does take place within the practice. The Committee noted the results of the pilot which suggested that foot sensation testing was mostly carried out by practice staff.

The Committee recommended that the new indicators should replace the current QOF indicators DM9 and DM10.

### **Committee Decisions**

The Committee recommended that both indicators are published on the NICE menu of indicators for consideration for the QOF and that these indicators should replace indicators DM9 and DM10.

### **8.5 Myocardial Infarction**

#### **NICE Consultation**

The following two indicators were the subject of stakeholder consultation by NICE:

1. *The percentage of patients with a history of myocardial infarction (from 1 April 2011 {from 1 October 2009 for the purposes of piloting} currently treated with an ACE inhibitor, aspirin or an alternative anti-platelet therapy, beta-blocker and statin (unless a contraindication or side effects are recorded)*
2. *The percentage of patients with a history of myocardial infarction who have a record of intolerance or allergy to an ACE inhibitor who are currently treated with an ARB (unless a contraindication or side effects are recorded)*

The NICE QOF programme team presented this summary of the briefing report to the Committee:

Many individual stakeholders noted their agreement with the inclusion of the two indicators, although there were a number of comments, summarised below, which raised concerns.

Some stakeholders asked whether contraindications from multiple drugs would result in high cumulative exceptions and whether both indicators could be combined, to provide an alternative to an ACE inhibitor.

One stakeholder commented that measuring performance of '*patients admitted with a heart attack who were prescribed an anti-platelet, a statin, a beta-blocker*' is part of the Vital Signs Tier 3 indicators

In relation to the second indicator, some stakeholders asked whether the indicator would apply retrospectively or to new cases. There was also uncertainty as to how the above indicator relates to current QOF indicator CHD 11:

*The percentage of patients with a history of myocardial infarction (diagnosed after 1 April 2003) who are currently treated with an ACE inhibitor or Angiotensin II antagonist.*

Some stakeholders commented that there may be low or zero denominators in some instances for the second indicator.

One stakeholder questioned whether the indicator was already sufficiently covered by CHD11 and was concerned that the indicator may set a precedent for justifying why GPs are prescribing second line treatments.

### ***NEC Development feedback on piloted indicators***

A potential barrier for the indicator relating to prescribing of the four drugs related to the perceived complexity of the indicators in the presence of contra-indications. The NEC also noted that alternatives to, for example, aspirin need stipulating in the accompanying guidance.

For the second myocardial infarction indicator, the perceived barriers related to local prescribing guidance in some areas and, potentially, a low proportion of people in some practices who may require an ARB. NEC stated that these indicators are likely to be cost effective given the evidence of direct therapeutic benefit.

### ***Committee Summary***

The Chair declared a part two session in accordance with the Public Order Act of 1960 which states the following:

*Representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.*

The minutes of the part two session are presented below.

In relation to the indicator incentivising the use of the four drugs, the Committee stated the baseline data from the pilot was quite low. The Committee heard that the baseline suggested that this is an area for quality improvement.

The Committee considered that both indicators could be combined so that ARBS are offered where the patient is ACE intolerant. The ETA recommended that this would be technically feasible.

### **Committee Decisions**

The Committee recommended that the two indicators should be merged together so that ARBs are offered where the patient is ACE intolerant, if technically feasible.

The Committee recommended that both indicators are published on the NICE menu of indicators for consideration for the QOF.

The Committee recommended that CHD11 should be replaced by the recommended new indicator.

### **8.6 Palliative Care**

#### ***NICE Consultation***

The following indicator was the subject of stakeholder consultation by NICE:

*The percentage of patients on the palliative care register who have a preferred place to receive end-of-life care documented in the records*

The NICE QOF programme team presented this summary of the briefing report to the Committee:

There was overall agreement with the inclusion of the indicator from stakeholders. A number of stakeholders stated that that they welcomed the indicator, and that it would help to support people to be given more choice in place of death and would place a much higher priority on palliative and end of life care than has historically been the case.

One stakeholder group suggested that the denominator should be all deaths in the practice, supported by a correspondingly lower standard QOF threshold, rather than all *patients on the palliative care register*. The rationale provided for this suggestion is that there is evidence from audit data showing

that the palliative care registers currently do not include all people who would benefit from the indicator.

In relation to specific comments, the following common themes were identified:

A key theme identified from stakeholder comments, including GPs, is that preferences around the location of care at the end of life are not static. A number of GPs commented that a sizable minority of people approaching the end of their life change their minds about their preferred location of care and it should be made clear that the purpose of the QOF indicator is to give patients choice and not to compel people to view home as the right place to die. In terms of implementation of the indicator, it was therefore felt important to ensure that patients and families would be aware that they can change their mind at any point.

There was a strong feeling from the consultation, including comments made by individual GPs, that the timing of this discussion is critical and sensitive and implementation of the indicator would need to be part of an evolving discussion.

One stakeholder commented that it is important that patients with respiratory disease (and any other conditions in which prognosis is uncertain) are appropriately included in the palliative care provision of the practice. It was noted that the disease trajectory for Chronic Obstructive Pulmonary Disease (COPD) is less predictable than for other conditions. A similar observation was made relating to the care of patients with certain types of neurological disease.

One stakeholder asked whether the indicator could document that an assessment had been undertaken in the patient's home (a GP visit). One stakeholder questioned whether the indicator would capture those patients with complex needs who have neither been listed on the register nor have had conversations about their care needs.

Exception reporting was highlighted as important for situations where patients may refuse to talk about end of life care, or who are indecisive, or where a discussion had taken place but the patient did not wish to take it further, or for patients where a discussion could not occur such as in patients with severe dementia.

It was commented that there are particular communities which, due to religious or cultural reasons, may be less willing to talk about end of life.

One stakeholder commented that the proposed indicator could be monitored and evaluated, to assess whether there is a need to further development and refinement to ensure that it reflects the choices of different groups in society regarding palliative care.

### ***NEC development feedback on piloted indicators***

The Committee was presented with the results of the indicator development and pilot feedback for this indicator.

The overall recommendation of the NEC was that there were significant barriers identified through the pilot that would preclude the indicator being published on the NICE menu of indicators for consideration for the QOF.

The NEC stated that this indicator is not amenable to cost effectiveness analysis. However, this did not mean that it is necessarily cost ineffective.

### ***Committee Summary***

The Chair declared a part two section in accordance with the Public Order Act of 1960 which states the following:

*Representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.*

The minutes of the part two session are presented below.

The Committee decided that it was not appropriate to include the statement “all deaths in the practice” within the indicator. This was due to incidences of sudden death skewing the figures, as there would be no opportunity for the GP to discuss end of life care with the patient in these cases.

The Committee noted that there are concerns from practices that there would be a rigid timeframe set within the indicator that would be difficult to meet due to the need to discuss palliative care at an appropriate point.

The Committee questioned how this indicator differed from the Gold Standard Framework approach to optimising the care for patients nearing the end of life that is already used widely within practices and includes further elements of care.

The Committee discussed the potential unintended consequence of the inclusion of this indicator in the QOF, which may lead to undue focus on one area of palliative care. Evidence from the pilot was provided which suggested that this indicator, when implemented, did have the potential for unintended consequences.

The Committee asked whether this indicator was the most appropriate way to address the issue of preferred place of death. The Committee noted that many patients do die in hospital, often due to lack of resources for home care.

The Committee considered that, whilst preferred place of death is an important area of end of life care, the QOF was not the mechanism by which this question should be addressed.

### **Committee Decisions**

The Committee stated that the level and severity of potential unintended consequences as identified by the piloting process by the NEC were sufficient to justify not publishing this indicator on the NICE menu of indicators for consideration for the QOF.

### **8.7 Serious Mental Illness (SMI)**

### **NICE Consultation**

The following six indicators were the subject of stakeholder consultation by NICE:

1. *The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months*
2. *The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 15 months*
3. *The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 15 months*
4. *The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol: hdl ratio in the preceding 15 months*
5. *The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose level or HBA1c in the preceding 15 months*
6. *The percentage of women aged 30-64 with schizophrenia, bipolar affective disorder and other psychoses who have a record of cervical screening within the last 5 years*

The NICE QOF programme team presented this summary of the briefing report to the Committee:

Some of the stakeholder comments related to both the consultation indicators and also indicators that are in the current QOF domain of mental health. Stakeholder comments that relate to both consultation indicators and those in the current QOF are:

- High exception reporting for SMI indicators could potentially influence whether proposed indicators could lead to improvements for those with serious mental illness
- The requirement to ensure that people who have recovered from a single episode of psychosis can be excluded from the indicator set
- Follow-up visits to this patient group should be incentivised

In relation to the piloted indicators, a common theme was the appropriateness of the proposed timeframes for the indicators (every 15 months) and that indicators could be extended, for example, to include appropriate referral or brief intervention.

In relation to specific issues relating to SMI indicators 3, 4 and 5 (blood pressure, cholesterol and HbA1c), stakeholders asked whether these indicators should be applied to all people on the mental health register or whether these should be age and risk dependent.

Stakeholders suggested that the age range for SMI 6 (cervical screening) is inconsistent with the age range for cervical screening which is 25 to 64 (21 to 60 in Scotland). Stakeholders also questioned why this is restricted to cervical screening and not breast and bowel screening.

### ***NEC Development feedback on piloted indicators***

The Committee was presented with the results of the indicator development and pilot feedback for these indicators.

The overall recommendation of the NEC was that there are uncertainties identified from the pilot that in themselves may not be sufficient to prevent an indicator being recommended by the Committee, but require the particular attention of the Committee.

The NEC stated that there was a difference in opinion/preferences across practices on the splitting of the current mental health indicator (MH9) into the discrete pilot indicators.

The NEC stated these indicators had the potential to be cost effective since they change the availability of information available to the treating clinician in a disease where there is a proven therapy.

Cost effectiveness analysis would involve a number of assumptions. The NEC stated that the cost-effectiveness of these indicators is currently unclear, but this did not mean that they were cost ineffective, but rather new studies are required to produce the data needed to determine their cost-effectiveness.

Threshold analysis suggested that the indicators could be cost effective across a range of points and thresholds.

For the indicator on cervical screening (SMI 6) the NEC stated that there was evidence for this indicator to be considered cost effective since it provides the treating clinician with information that is likely to be acted upon.

### ***Committee Summary***

The Chair declared a part two section in accordance with the Public Order Act of 1960 which states the following:

*Representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.*

The minutes of the part two session are presented below.

The Committee agreed that there was good evidence to recommend the indicators relating to BMI, alcohol and blood pressure. However, the Committee considered the age range of the indicators relating to cholesterol and blood glucose and noted the evidence from the NICE guideline on bipolar disorder, which recommended cholesterol measurement in people aged 40 years and over.

The Committee discussed the role of HDL cholesterol. It was noted that HDL cholesterol, along with total cholesterol, are integral components of commonly used cardiovascular scores (e.g. JBS2, QRISK2 and ASSIGN) and noted that

people with pre-existing cardiovascular disease (e.g. stroke or ischaemic heart disease) were already known to be at high risk and did not require formal cardiovascular risk factor assessment.

The Committee agreed that there was insufficient evidence to support the view that all people with SMI should have cholesterol and blood glucose testing, and that the age band of 40 years and older, on which the Committee had made its original recommendations for development, should be reinstated for these indicators.

The Committee agreed that the uptake of cervical services is lower in this group than in the general population. The Committee agreed that the age range for this indicator should be changed to reflect the age range used in the current cervical screening indicator.

The Committee added that the uptake of mammography services is also much lower in this group but that breast screening is not performed by general practices in the same way as cervical screening.

### **Committee Decisions**

The Committee recommended that the indicators are published on the NICE menu of indicators for consideration for the QOF with amendments to the age range for the indicators relating to cholesterol and HbA1c and to the indicator relating to cervical screening.

### **Item 9: Review of Current QOF Indicators**

#### ***9.1 Mental Health - MH7***

*MH7: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who do not attend the practice for their annual review who are identified and followed up by the practice team within 14 days of non-attendance*

### **Committee Summary**

The Committee was presented with the results of a review of this indicator.

The Committee considered three interlinked feasibility issues for this indicator:

The first feasibility issue considered related to the current mechanisms of exception reporting in the QOF, and how under certain circumstances a practice can exception report patients if they do not attend or make an appointment to attend their mental health review (QOF indicator MH9). Where exception rule criterion A is used, this automatically excludes patients from the whole mental health QOF indicator set including indicator MH7, which is intended to follow up patients who do not attend their mental health review

A second significant feasibility issue was considered: this relates to the difficulty of identifying the target population, that is, those patients who have not attended their appointment for a mental health review (the denominator for MH7), consistently and with confidence across practices.

The Committee heard that, technically, the indicator works on the premise, that for reviews, practices would send out letters detailing an appointment date and time for a review – as is standard practice for secondary care appointments. Therefore, if a patient does not attend their appointment the practice could, with confidence, identify that patient as a ‘Did Not Attend’ (DNA) for the mental health review. However, practices tend to send out invitation letters asking the patient to make an appointment at their convenience. This raises the question of whether a failure on the part of the patient to respond to a letter to make an appointment should be classified as a DNA and how this decision should be reached given that they have not had an appointment to miss.

The Committee was advised that the differing mechanisms by which practices manage the call and recall of patients, and the interaction of this with the current mechanism of QOF exception reporting means that there are significant challenges to identifying the target population (the denominator for indicator MH7) consistently and accurately across practices.

A third consideration for indicator MH7 was identified in that, if a practice follows up all their patients under indicator MH9, practices are unable to achieve any of the points for the indicator MH7 as there are no patients to

follow up. This means that it could be argued that practices who are achieving better practice in terms of following up their mental health patients for review, are achieving a lower points score on QOF than practices who are less successful in this respect.

The Committee was advised that data from the NHS IC would suggest that around 27, 000 people were followed up under MH7 for non attendance of their mental health review.

The Committee agreed that it is uncertain how people are identified to be in the target population for this indicator, and that the current mechanisms of exception reporting make this indicator problematic.

The Committee agreed that the follow up of patients who do not attend their mental health review should be incentivised through the current QOF indicator MH9 or the unbundled MH9 indicators.

### **Committee Decisions**

The Committee agreed to recommend that indicator MH7 should be retired from the QOF due to lack of technical feasibility.

### ***9.2 Recovery from serious mental illness***

#### **Committee Summary**

The Committee considered the unintended consequence of the current mental health indicators whereby people who feel that they have recovered from a serious mental illness are invited to attend mental health reviews, and how this may cause distress to some people.

The Committee heard expert advice that the problem arises from there being no agreed definition of what constitutes recovery from serious mental illness. The lack of agreement over the meaning of recovery also creates particular difficulties in terms of reliable measurement.

A proposed solution was suggested to the Committee. This was that the business rules could be updated so that patients could be excluded at the

indicator level. This would leave these individuals on the mental health register, whilst a consensus is reached as to the nature of recovery, but would allow them to be removed from indicator denominators. This would entail the development of Read codes.

Appropriate guidance would need to be produced to support the use of appropriate Read codes for indicator exclusions.

### **Committee Decisions**

The Committee and Chair agreed that it was clinically appropriate to keep people on the mental health register without the requirement to follow them up under the associated mental health indicators. The Committee acknowledged that it was a small but important cohort of patients.

The Committee recommended that exclusion codes from mental health indicators should be explored and appropriate guidance developed to support the use of such exclusion codes. This work would be carried out by the NHS IC with support from the ETA and the NEC.

### **9.3 Mental Health - MH4 and MH5**

*MH4: The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 15 months*

*MH5: The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the previous 6 months*

### **Committee Summary**

The Committee was presented with the conclusions of the expert review of indicators MH4 and MH5.

NEC discussed a recent alert from the National Patient Safety Agency (NPSA) regarding lithium monitoring.

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The Committee asked if the data from NPSA could have occurred in a primary care setting. NEC said there was no data on which clinical setting the incidents had come from.

The NEC advised the Committee that in most instances lithium would have been prescribed to the patient in primary care, thus prevention of incidents as reported by NPSA could be best achieved through regular monitoring in general practice.

The Committee noted that this was an indicator that they had previously recommended to be retired, at higher risk, from the QOF on the basis of high achievement, low variation and low exception reporting. However, the Committee agreed that the QOF should be flexible to changes in the evidence base and should be able to respond to changes appropriately and in a timely manner.

The Committee agreed that MH4 should not be retired from the QOF in light of the NPSA alert.

The Committee also considered changing the interval for MH4 from 15 months to 6 months. However, the Committee felt that, although this would be the aim in clinical practice, it would not be feasible as a QOF indicator. The Committee agreed that the interval should be reduced to every 9 months to bring the indicator closer in line the NICE guidelines. It was noted that this would be consistent with other indicators where a three month period was added to allow for patients being late for appointments or patients whose latest reading is unexpectedly abnormal and who need some remedial action.

The Committee considered changing the review interval for indicator MH5 from every 6 months to every 3 months taking into consideration recommendations from the NICE guideline on Bipolar Disorder which recommends monitoring serum lithium levels every 3 months.

The Committee agreed the interval should be reduced to be closer in line with NICE guidance. However, the Committee did not agree that the interval

should be reduced to every 3 months at this time, but that the indicator interval should be reduced to 4 months.

The Committee also asked if the indicator could be changed so that measurement of lithium levels at 4 month intervals throughout the year could be incentivised. The ETA advised that this is currently technically very difficult but could be explored at a later date with the NHS IC.

### **Committee Decisions**

The Committee recommended that MH4 should not be retired from the QOF in light of data from the NPSA alert.

The Committee recommended that the time interval for MH4 be changed from 15 months to 9 months and the time interval for MH5 should be changed to previous 4 months.

The Committee recommended that the technical feasibility of an indicator which incentivises measurement of serum lithium levels every four months throughout the year should be explored by the NHS IC with support from the ETA.

### **9.4 Cancer - Cancer 3**

*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*

### **Committee Summary**

The Committee was presented with the conclusions of the expert review of indicator Cancer 3.

The Committee discussed proposals to: decrease the length of time of the initial review from 6 to 3 months; introduce a new indicator that incentivises an annual health check; split the current indicator into its constituent parts (unbundling); and to consider whether the indicator should include those with new metastatic cancer.

The Committee reviewed the evidence presented to it by the NEC. The Committee noted the evidence that the period around diagnosis is a critical one for patients and this would support reducing the time interval from 6 months to 3 months.

However, the Committee expressed concerns about reducing the timeframe for patient review to three months from diagnosis, as during this time many patients are managed in secondary care and the Committee considered that it therefore may not be appropriate to request a review during this time. They felt that more research and evidence on the feasibility of reviewing patients within 3 months of diagnosis would be needed for the Committee to reach a decision on this.

The Committee agreed that the diagnosis of metastatic cancer is not as clear as the diagnosis of other cancers, and therefore the indicator should not be extended to include metastatic cancer without further feasibility assessment.

The Committee discussed the partial unbundling of this indicator but agreed that the unbundling may detract from a holistic approach to the cancer review that the Committee felt was important. The Committee agreed with the expert review of the indicator that the cancer review should be carried out face to face.

### **Committee Decisions**

The Committee could not reach a consensus on the timeframe for reducing the cancer review from 6 months to 3 months and agreed that further assessment of its feasibility and a clearer evidence base would be needed before the Committee could make a recommendation. The Committee recommended that the NEC explore the feasibility of including new metastatic cancer. The Committee decided against the partial unbundling of Cancer 3. The Committee recommended that the cancer review should be face to face.

### **9.5 Palliative Care – PC2**

*PC 2: The practice has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed*

### **Committee Summary**

The Committee was presented with the conclusions of the expert review of indicator PC2.

The Committee noted that the QOF guidance for the palliative care register states that placing a patient on the palliative care register is based on a judgment that death is likely to occur within 12 months.

The Committee noted that the expert review suggested that around two thirds of new patients on the register were not able to be discussed in a multidisciplinary case review meeting (as stated in PC2) within one month of going onto the palliative care register and that it is not uncommon for patients to be put onto the register when they are within less than 3 months of death.

The Committee noted that with the present requirement to have a meeting every three months, it is therefore likely that some patients added to the register die before being discussed.

The Committee noted that the expert review of the indicators suggested that it would not be feasible for a patient to be discussed as part of a new patient multi-disciplinary team (MDT) meeting within one month of being added to the palliative care register. This could mean that many professionals would need to gather frequently to discuss potentially one new patient and this would lead to implementation and feasibility difficulties.

The Committee discussed the suggestion that an initial palliative care review could be undertaken within one month of the patient being added to the palliative care register but that this review would need to be a face to face consultation and not an MDT review.

Overall, the Committee considered that there was a potential for unintended consequences for an indicator incentivising a review within one month of the

patient being added to the register as this may result in patients being added to the palliative care register inappropriately.

### **Committee Decisions**

The Committee agreed that no changes were to be made to this indicator. There was no evidence on which to propose a change.

### **9.6 Asthma – Asthma 8**

*Asthma 8: The percentage of patients aged eight and over diagnosed as having asthma from 1 April 2006 with measures of variability or reversibility*

### **Committee Summary**

The Committee were presented with the conclusions of the expert review of indicator Asthma 8.

A proposed amendment to the indicator was suggested:

*The percentage of patients, 5 years and over diagnosed as having asthma from 1 April 2010 in whom the diagnosis of asthma has been made according to the criteria in the current BTS-SIGN guideline and clearly documented in the patient's medical record within 3 months of the diagnosis having been first recorded, and the proportion of children reaching the age of 5 years after 1 April 2010 with an existing diagnosis of asthma who have had the diagnosis reviewed and criteria recorded with one year of becoming 5 years*

The ETA stated that the proposed indicator has significant technical feasibility problems in particular relating to clinical coding.

The Committee agreed that the age range for the current indicator should be reduced to five years to bring it into line with British Asthma Guidelines 2009/BTS Guideline No 101.

The Chair noted that if there were questions around the technical feasibility, then the indicator would need to go for further development.

### **Committee Decisions**

The Committee agreed that the age range for the current indicator should be reduced to five years and over but due to concerns about the technical feasibility of the proposed new indicator, the feasibility should be considered further by the NHS IC with support by the ETA to ensure technical feasibility.

### **9.7 Depression – DEP1, DEP2 and DEP3**

*DEP 1: The percentage of patients on the diabetes register and /or the CHD register for whom case finding for depression has been undertaken on one occasion during the previous 15 months using two standard screening questions*

*DEP 2: In those patients with a new diagnosis of depression, recorded between the preceding 1 April to 31 March, the percentage of patients who have had an assessment of severity at the outset of treatment using an assessment tool validated for use in primary care*

*DEP 3: In those patients with a new diagnosis of depression and assessment of severity recorded between the preceding 1 April to 31 March, the percentage of patients who have had a further assessment of severity 5-12 weeks (inclusive) after the initial recording of the assessment of severity. Both assessments should be completed using an assessment tool validated for use in primary care*

### **Committee Summary**

#### **DEP1**

The Committee was presented with the conclusions of the expert review of indicator DEP1.

The Committee heard evidence from the NEC on the validity of the screening questions. The Committee discussed the low specificity of the Whooley screening questions and how follow-up questions are sometimes required.

The Committee noted the results of the expert review of this indicator. The Committee noted that the latest version of the updated NICE depression

guidelines (2009) included a new systematic search for cross-sectional studies to assess tools for identifying depression. The guideline supported the use of the Whooley questions. The Guideline Development Group concluded that in the first stage of case identification the Whooley questions remained an appropriate tool for depression. The Committee agreed that the questions should be asked as part of a consultation.

## **DEP2**

The Committee was presented with the conclusions of the expert review of indicator DEP2.

The Committee considered whether there should be a change of wording to this indicator so that the indicator reads '*time of diagnosis*' as opposed to '*outset of treatment*'.

The Committee agreed that the indicator wording should be changed along the lines suggested but the definition of '*time of diagnosis*' technically may require some further work by the NHS IC.

## **DEP3**

The Committee was presented with the conclusions of the expert review of indicator DEP3.

The Committee heard evidence from the NEC on the timeframe for the further assessment of severity.

NEC said that there is a stigma surrounding depression and that many GPs feel uncomfortable treating it, and consequently GPs feel uncomfortable with depression indicators.

The Committee noted that there was no evidence for the 5-12 week timeframe for the further assessment of severity. The Committee added that the NICE guideline on depression suggests follow up of 2 to 4 weeks in the first 3 months, and then at longer intervals if response is good.

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The Committee noted that the further assessment of severity within 5 weeks is often at odds with clinical practice and 28 day prescription cycles.

The Committee agreed that a 4-12 week timeframe would align better with clinical practice.

The Committee discussed the use of differing screening questions and agreed that telephone interviews work well for PHQ9 but not for HAD.

### **Committee Decisions**

The Committee agreed that there were no changes required to DEP1.

The Committee agreed that the wording DEP2 should be changed to 'time of diagnosis'.

The Committee agreed that the timeframe for assessment of severity should be changed to 4–12 weeks.

### **9.8 Atrial Fibrillation – AF3**

*AF3: The percentage of patients with atrial fibrillation who are currently treated with anti-coagulation drug therapy or an anti-platelet therapy*

### **Committee Summary**

The Committee was presented with the conclusions of the expert review of indicator AF3.

The Committee agreed with the expert review that there was a need for structured risk assessment to take place to incentivise appropriate therapy for those people with atrial fibrillation at differing risk.

The Committee agreed that indicator development for this area should explore differing approaches to assessment of risk.

The Committee discussed the potential shortcomings of the CHADS<sub>2</sub> in assessment of risk.

The ETA advised that it is better to stratify risk using a score rather than high/medium/low rating as these meanings can change over time.

### **Committee Decisions**

The Committee agreed that an indicator should be developed on structured risk assessment for people with atrial fibrillation and indicators to incentivise appropriate therapy for those people with atrial fibrillation at differing risk.

#### **9.9 Diabetes – DM23 and DM24**

*DM 23: The percentage of patients with diabetes in whom the last HbA1c is 7 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months*

*DM 24: The percentage of patients with diabetes in whom the last HbA1c is 8 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months*

### **Committee Summary**

The Committee was presented with the conclusions of the expert review of indicators DM23 and DM24.

The Committee noted that uncertainty had been expressed about the safety of the HbA1c target of 7% with regards to indicator DM23.

The Chair declared a part two section in accordance with the Public Order Act of 1960 which states the following:

*Representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.*

The minutes of the part two session are presented below.

The expert review of DM23 suggested that younger people with little co-morbidity were more likely to benefit from tighter control of HbA1c, whereas

less stringent goals may be more appropriate for people with established cardiovascular disease, those with a history of hypoglycaemia, or those requiring multiple medications or insulin to achieve a target HbA1c of 6.5%.

The expert review of DM23 noted that the NICE guideline on type 2 diabetes recommends an HbA1c target of 6.5% for people with type 2 diabetes in general. However, the targets mentioned in the NICE clinical guideline are qualified by advice that they should be tailored to individual circumstances. The accompanying detailed algorithms in the NICE guideline make clear that a less stringent target (7.5%) is appropriate for individuals with a longer duration of diabetes and those who require third-line therapy.

The expert review noted that the recent SIGN guideline on type 2 diabetes recommends that an HbA1c target of 7.0% (53 mmol/mol) among people with type 2 diabetes is reasonable to reduce the risk of microvascular disease and macrovascular disease.

The SIGN guideline also recommends that a target of 6.5% (48 mmol/mol) may be appropriate at diagnosis and that targets should be set for individuals in order to balance benefits with harms, in particular hypoglycaemia and weight gain.

The Committee was in agreement with the summary and interpretation of the evidence set out in the expert review. The Committee considered reducing the threshold for indicator DM23 as suggested by the expert review. However, it was noted that reducing the threshold would mean that the threshold would be below current achievement levels for DM23.

The Committee considered the recommendations contained in the recent SIGN guideline were appropriate for clinical practice, but had concerns that they were not sufficiently strong to form the basis for an indicator incentivising a target for HbA1c of 7.0%. The Committee further noted that there was a difference between an audit target which may be appropriate for the QOF, and a target that an individual practitioner may use with an individual patient in clinical practice. The Committee noted that in order to achieve an average

practice target of HbA1c of 7.0%, a clinician may need to aim for a HbA1c below this in individual patients.

The Committee agreed that there was a potential risk of unintended consequences for this indicator in relation to a subset of people with diabetes. The Committee agreed that reducing thresholds would not be the most appropriate method to mitigate this risk.

### **Committee Decisions**

The Committee recommended that the threshold for DM23 should remain unchanged but that the HbA1c target should be increased to 7.5%.

The Committee recommended that there should be no change to DM24.

### **9.11 Diabetes Register – DM19**

*DM 19: The practice can produce a register of all patients aged 17 years and over with diabetes mellitus, which specifies whether the patient has Type 1 or Type 2 diabetes*

### **Committee Summary**

The Committee was presented with the results of a review of the diabetes register.

The Committee noted that the current diabetes register includes only patients who are coded with one of two of the many possible Read codes for diabetes.

The Committee noted that there are many other ways a patient might legitimately be coded with diabetes that leave them outside the QOF disease register, and that people coded with other diabetes mellitus codes may, by virtue of being excluded from the QOF diabetes register, miss out on recall or screening linked to the QOF.

The Committee noted that a greater understanding and knowledge of the complexities of diabetes has led to an increasing difficulty in some instances of accurately diagnosing or classifying the type of diabetes.

The Committee noted that an expert working group has been established to examine causes, extent and nature of misclassification and miscoding of diabetes in primary care. The working group plan to make recommendations on the classification of diabetes.

The ETA discussed the structure, form and history of Read codes and how they could be made simpler for GPs to choose, and stated that caution should be exercised in making any changes to the register

### **Committee Decisions**

The Committee agreed that, as there is a diabetes working group currently examining this issue, no decision would be made on this indicator until the working group publish their recommendations later in 2010.

### **9.12 Coronary Heart Disease – CHD2**

*CHD 2: The percentage of patients with newly diagnosed angina (diagnosed after 1 April 2003) who are referred for exercise testing and/or specialist assessment*

### **Committee Summary**

The Committee was presented with the results of a review of this indicator.

The Committee discussed whether CHD2 should be retired and outlined the following options:

- Retire the indicator from the QOF
- Revise the indicator to be consistent with the NICE clinical guideline 95 on chest pain of recent onset

The Committee noted that the recently published NICE clinical guideline 95 on chest pain of recent onset states that exercise testing (exercise ECG) should not be used to diagnose or exclude the diagnosis of stable angina for people without known coronary artery disease (CAD).

The Committee noted that referring all people with suspected angina to specialist assessment would not be in line with the recently published NICE clinical guideline.

The Committee noted that the NICE clinical guideline 95 states that angina can be diagnosed on the basis of a clinical assessment that includes a calculation of the estimated likelihood of CAD. Where typicality of symptoms, age, sex and risk factors mean the estimated likelihood of CAD is greater than 90%, then further diagnostic investigation is unnecessary and the patient should be managed as having angina.

The Committee considered the retirement of CHD2 from the QOF. However, the Committee agreed the importance of making timely and accurate diagnosis in patients who present with suspected angina. The Committee agreed that there was potential for unintended consequences to patient care if this indicator was retired from the QOF, since referral for specialist assessment would be still indicated for many patients with suspected angina.

The Committee was advised that it would be possible to revise the indicator to allow patients in whom the diagnosis has been made on clinical assessment in primary care to be excluded. This would mean that the indicator would incentivise referral of people with suspected angina whose diagnosis cannot be firmly made in primary care.

The Committee agreed that CHD2 should not be retired but that the reference to “exercise testing” should be removed.

A technical solution would need to be investigated to provide an exclusion from this indicator where diagnosis is based on clinical assessment alone, i.e. to incentivise referral where there is diagnostic doubt. This would need to be developed by the NHS IC.

### **Committee Decisions**

The Committee recommended that CHD2 should not be retired but that the reference to “exercise testing” should be removed and the indicator amended.

### **9.13 CVD Risk Assessment Tools**

PP 1: *In those patients with a new diagnosis of hypertension (excluding those with pre-existing CHD, diabetes, stroke and/or TIA) recorded between the preceding 1 April to 31 March: the percentage of patients who have had a face to face cardiovascular risk assessment at the outset of diagnosis (within three months of the initial diagnosis) using an agreed risk assessment tool*

#### **Committee Summary**

The Committee considered the review of this indicator. The Committee was informed that in February 2010, NICE withdrew the guidance relating to a particular method of cardiovascular risk estimation so that the decision could be left to the NHS locally to use the method best suited to their requirements.

The Committee was advised that four risk tools should be used for the QOF. These were: Framingham 1991, JBS-2, ASSIGN (Scotland only) and QRISK.

The Committee noted that the QOF guidance should be updated to reflect the agreed risk tools and the indicator wording changed to reflect the age range for risk estimation.

#### **Committee Decisions**

The Committee agreed that QOF guidance should be updated to reflect the agreed risk tools outlined by the QOF programme team and that the indicator wording should be changed to reflect the age range for risk estimation.

### **Agenda Item 10**

#### **Indicators for Review – Stakeholder Suggestions**

The Committee was asked to consider and agree a list of proposed actions relating to existing QOF indicators requiring a review, compiled from comments received from stakeholders.

<b>QOF Area</b>	<b>Suggestion</b>	<b>Action</b>
<b>COPD 10:</b> The percentage of patients	Stakeholders question the evidence base for annual	Recommend that the evidence base for annual

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with COPD with a record of FeV1 in the previous 15 months	repeat spirometry in patients with stable COPD is reviewed	assessment in people with stable COPD is reviewed
<b>CS1:</b> The percentage of patients aged from 25 to 64 (in Scotland from 21 to 60) whose notes record that a cervical smear has been performed in the last five years	Stakeholders suggest that thresholds and exceptions to this indicator are reviewed and to split CS1 (for England) into 2 indicators to reflect the fact that women aged 25-49 should be invited every 3 years and women aged 50-64 should be invited every 5 years.	Recommend reviewing the feasibility of splitting CS1 to reflect the differing ages and follow up intervals across the four countries
<b>DEP 1:</b> The percentage of patients on the diabetes register and /or the CHD register for whom case finding for depression has been undertaken on one occasion during the previous 15 months using two standard screening questions	Stakeholders suggest that DEP1 is expanded to include case finding of depression for COPD and stroke	Recommend that the evidence base for expanding DEP1 to include other disease groups is assessed. This review should also be done with reference to the recent NICE clinical guideline 91: Depression with a chronic physical health problem
<b>DEP 2:</b> In those patients with a new diagnosis of depression, recorded between the preceding 1 April to 31 March, the percentage of patients who have had an assessment of severity at the outset of treatment using an assessment tool validated for use in primary care  <b>DEP3:</b> In those patients with a new diagnosis of depression and assessment of severity recorded between the preceding 1 April to 31 March, the percentage of patients who have had a further assessment of severity 5-12 weeks (inclusive) after the initial recording of the	Stakeholders suggest that DEP 2 and DEP 3 are expanded to include an assessment of anxiety with a validated tool	The Committee did not agree to recommend at this time expanding the depression indicators to include anxiety, noting that mixed anxiety and depression is very common and is already included in the depression indicators

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<p>assessment of severity. Both assessments should be completed using an assessment tool validated for use in primary care</p>		
<p><b>DM17</b> : The percentage of patients with diabetes whose last measured total cholesterol within the previous 15 months is 5mmol/l or less</p>	<p>Stakeholders suggest that this indicator should be reviewed to include an assessment of CVD risk status annually and a full lipid profile (including HDL-C and TG)</p>	<p>Recommend that the evidence base for expanding DM17 is reviewed in the context of CG87 on type 2 diabetes</p>
<p><b>Blood Pressure targets</b></p>	<p>Stakeholders suggest the unification of blood pressure targets for patients with chronic kidney disease (CKD), diabetes, proven cardiovascular disease, and any combination of these</p> <p>Stakeholders suggest unification of recommendations for intervals for blood testing</p> <p>Stakeholders suggest the lower age range for the blood pressure indicators in the organizational domain are lowered to age 16</p>	<p>Recommend that blood pressure targets in the QOF are reviewed in the context of NICE and SIGN guidelines and other NHS evidence accredited sources of evidence.</p> <p>Recommend that the evidence base for the age range for blood pressure indicators in the organisational domain are reviewed</p>
<p><b>ASTHMA 8:</b> The percentage of patients aged eight and over diagnosed as having asthma from 1 April 2006 with measures of variability or reversibility</p>	<p>Stakeholder suggests that the lower age limit for diagnosis should be 5 years and not 8 as appropriate testing can be undertaken at this age.</p> <p>Stakeholders suggest that the lower age ranges for the QOF diseases registers are reviewed</p>	<p>The Committee noted that it had already recommended that the age range of the asthma register should be reviewed to ensure technical feasibility. The Committee did not agree to recommend a review of the age range for other disease registers</p>

**Item11: Review of decisions and general discussion (Part two section only)**

The Chair declared a part two section in accordance with the Public Order Act of 1960 which states the following:

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*Representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.*