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

Development feedback report on piloted indicator(s)

QOF indicator area: COPD

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 COPD AND Medical Research Council (MRC) Dyspnoea Scale ≥3 at any time in the preceding 15 months, with a record of oxygen saturation value within the last 15 months.

2. The percentage of patients with COPD and Medical Research Council (MRC) Dyspnoea Scale ≥3 at any time in the preceding 15 months, with a record of a referral to a pulmonary rehabilitation programme (excluding patients on the palliative care register).

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 RAM 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

Comments	Response	NHSIC Summary
Indicator 2 excludes people who are on the palliative care register? – This sounds like it may have policy considerations. We do not currently exclude palliative care patients from other chronic condition indicators – this may have implications. Why have we introduced this here?	This was added in because the GP RAND panel wanted to exclude such patients.	There may be policy implications if it is agreed that patients on the palliative care register should be excluded.
In indicator 2 the referral can be anywhere in the record, this will mean rewarding practices repeatedly for something they may have done once 3 years ago	The issue clinically is the value or not of repeated referrals to pulmonary rehabilitation The benefits of pulmonary rehabilitation appear to wane with time. There is limited evidence concerning the benefits of attendance at further pulmonary rehabilitation programmes. If at a later stage we add the last 15 months clause then we will be encouraging GP's to refer when it is not appropriate	May require double payment rules?

[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

Oxygen saturation Read codes, need to decide which codes to use if the indicator goes live. This may require a new V2 code for 'Oxygen saturation at periphery' with a synonym of 'spO2 - saturation of peripheral oxygen.	Suggest: We request a new V2 code for 'Oxygen saturation at periphery' with a synonym of 'spO2 - saturation of peripheral oxygen'. We can then decide whether to use the procedure codes, observable codes or both if the indicator progresses to live QOF.	Need to ensure there is enough time to request appropriate codes if required.
Are we looking for an oxygen saturation read code or a code and a value	In piloting do a count of recording of oxygen saturation with a value and without a value	The business rules will be more complex if they need to look for a code and a value.
		Need to consider the following if negotiated into live: Can you decline an offer of referral to a pulmonary rehabilitation programme? Is there any ambiguity over what a pulmonary rehabilitation programme is?

Acceptability

General comments

None.

Acceptability indicator 1

More than two-thirds of practices felt that this indicator should be included in the QOF. Many of the pilot practices were doing this routinely anyway and had been for some time, often irrespective of MRC score. Those who were not doing it routinely were often recording this on an ad hoc basis and commented that participating in the pilot had motivated them to add this aspect of care to their COPD review template and to make it routine.

Almost all practices had access to at least one pulse oximeter within the practice. Only 1 practice reported buying a pulse oximeter specifically for the pilot. Some practices had already invested in a pulse oximeter for each consulting room and the doctor's home visit bags. However, some practices noted that there could be resource implications for practices who had yet to make this investment (average price about £60),

Practices reported that this was generally popular with patients who liked keeping an eye on their scores. Some practices incorporated oxygen saturation values into their COPD self-management plans and commented that this helped to keep patients involved with their care.

Just over a fifth of practices did not think this should be included in QOF. Where this was the case, the primary reason was that the GPs questioned the value of a single at rest reading when making decisions about clinical care. These GPs commented that they would make treatment decisions based upon symptoms and patient quality of life rather than oxygen saturation levels. However, other clinicians reported that they found it useful in establishing a baseline, when making decisions about home oxygen therapy, the need or otherwise for antibiotics and when giving smoking cessation advice.

Acceptability indicator 2

Two-third of practices thought that this indicator should be included in QOF. It was generally perceived as evidence-based, a good thing to do and with the potential for patient benefit. Generally practices thought that this was either a primary care responsibility or a shared responsibility with secondary care.

Approximately a quarter of practices did not think that this indicator should go into QOF (the remainder being ambivalent about inclusion). For many, this was due to poor access to services locally. Across the pilot, practices' access to pulmonary rehabilitation was patchy; some practices were able to access services easily, a number did not have access to a service at all and others could only access services which set their own referral criteria. Some practices had to refer patients to either local respiratory physicians or COPD management teams who would then assess the patient for their suitability for pulmonary rehabilitation. They expressed concern that, as written, they would not be able to participate in this indicator.

Concern was also expressed about the use of an MRC score of ≥3 as the determining factor for referral. Some practices felt that this was a little restrictive as patients with lower scores could still benefit. Others felt that offering referral with a

score of ≥4 was more realistic and would avoid local services becoming overwhelmed by demand. A minority of practices reported waiting times for rehabilitation of up to a year.

In relation to the wording of the indicator, most practices felt that this should be rewritten to 'offer referral' for reasons of patient autonomy and long waiting times. Some concern was expressed that if the indicator required patients to be referred or to have attended a programme then levels of exception reporting might be higher than otherwise expected. A minority of practices commented that their local pulmonary rehabilitation services were difficult for patients to access, resulting in high levels of referrals being declined.

Acceptability recommendation indicator 1

- There is a high degree of confidence that there are no major barriers/ risks/ issues/ uncertainties identified from the pilot in terms of implementation that would preclude this indicator from being implemented.

Acceptability recommendation indicator 2

- There is a high degree of confidence that there are no major barriers/ risks/ issues/ uncertainties identified from the pilot in terms of implementation that would preclude this indicator from being implemented.

Implementation

Assessment of piloting achievement

1. The percentage of patients with COPD AND Medical Research Council (MRC) Dyspnoea Scale ≥3 at any time in the preceding 15 months, with a record of oxygen saturation value within the last 15 months.

COPD INDICATOR 1	Baseline	Final
Number of Practices Uploading	**22**	**22**
Practice Population	**158,884**	**160,001**
Patients on COPD Register	**2,532**	**2,640**
Excluded regardless of whether they meet Numerator criteria	*less*	*less*
MRC1_DAT 15 Months ago	1,476	1,618
Excluded if they do not meet Numerator criteria		
Registered in last 3 months	4	2
COPD Exlusion in last 15 months	29	29
Diagnosis in last 3 months	8	4
Total Exclusions	**1,517**	**1,653**
	equals	*equals*
COPD Indicator 1 Denominator	**1,015**	**987**
COPD Indicator 1 Numerator	**289**	**523**
Numerator as % of Denominator	**28.47%**	**52.99%**

Assessment of piloting achievement

2. The percentage of patients with COPD and Medical Research Council (MRC) Dyspnoea Scale ≥3 at any time in the preceding 15 months, with a record of a referral to a pulmonary rehabilitation programme (excluding patients on the palliative care register).

COPD INDICATOR 2	Baseline	Final
Number of Practices Uploading	**22**	**22**
Practice Population	**158,884**	**160,001**
Patients on COPD Register	**2,532**	**2,640**
Excluded regardless of whether they meet Numerator criteria	*less*	*less*
Patient has Palliative Care code	22	28
MRC1_DAT 15 Months ago	1,463	1,603
Excluded if they do not meet Numerator criteria		
Pulmonary Rehab Exclusion within last 15 months	0	74
Registered in last 3 months	4	4
COPD Exclusion in last 15 months	38	41
Diagnosis in last 3 months	13	8
Total Exclusions	**1,540**	**1,758**
	equals	*equals*
COPD Indicator 2 Denominator	**992**	**882**
COPD Indicator 2 Numerator	**99**	**161**
Numerator as % of Denominator	**9.98%**	**18.25%**

Summary

- Two-thirds of practices felt that routine recording of oxygen saturation levels should be included in QOF.
- All but one pilot practice had access to a pulse oximeter prior to the pilot.
- However, the clinical value of a one-off measurement was questioned by some GPs.
- Pulmonary rehabilitation was generally perceived as evidence based, a good thing to do and beneficial to patients.
- Access to pulmonary rehabilitation services was patchy and sometimes inconsistent which had an impact on the acceptability of this indicator.

Changes in practice organisation

General comments

None.

Specific comments indicator 1

For many practices this was routine care prior to the pilot. Those for whom it was not, made amendments to their COPD review template to capture this information and to make this aspect of care routine.

Specific comments indicator 2

None.

Resource utilisation and costs

General comments

None.

Specific comments indicator 1

It was noted that where practices had not already invested in pulse oximeters then this would have resource implications. However, only 1 practice reported purchasing a pulse oximeter specifically to participate in the pilot. All other practices had access to at least one pulse oximeter and often more than this.

There was little, if any, increase in workload associated with this indicator.

Specific comments indicator 2

Most practices felt that this would require little or no extra work to implement.

Barriers to implementation

General comments

None.

Specific comments indicator 1

Some practices may need to purchase pulse oximeters to participate in this indicator.

Specific comments indicator 2

The main barriers to implementation are the patchy availability of services and the setting of local referral criteria which may not be consistent with QOF recommendations for referral.

Assessment of exception reporting

Specific comments indicator 2

Most practices felt that the wording of the indicator should be amended to 'offered referral' due to the high number of patients who decline and the long waiting times in some areas. If the wording of 'referred' is retained, then exception reporting rates may be higher than expected as a result of patients exercising their right to refuse a referral.

Assessment of potential unintended consequences

Specific comments indicator 2

Not all practices were able to access these services directly which may affect achievement and participation rates.

Implementation recommendation indicator 1

- There is a high degree of confidence that there are no major barriers/ risks/ issues/ uncertainties identified from the pilot in terms of implementation that would preclude this indicator from being implemented.

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

None.

Overall recommendation

Indicator 1

- There is a high degree of confidence that there are no major barriers/ risks/ issues/ uncertainties identified from the pilot in terms of implementation that would preclude this indicator from being implemented.

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

It is proposed that indicator 2 is reworded to:

The percentage of patients with COPD and Medical Research Council (MRC) Dyspnoea Scale ≥3 at any time in the preceding 15 months, with a record of an *offer of a referral* to a pulmonary rehabilitation programme (excluding patients on the palliative care register).

Appendix A: Indicator details

Recommendation(s) presented and prioritised by the Advisory Committee

Provisional indicator generated by NEC

The percentage of patients with COPD and Medical Research Council (MRC) Dyspnoea Scale ≥3 with a record of oxygen saturation value in the previous 15 months.

Supporting NICE recommendations for the provisional indicator taken from NICE clinical guideline 101 on COPD

NICE Recommendation 1.2.5.4 (CG101)

The need for oxygen therapy should be assessed in:

- all patients with very severe airflow obstruction (FEV1 < 30% predicted)
- patients with cyanosis
- patients with polycythaemia
- patients with peripheral oedema
- patients with a raised jugular venous pressure
- patients with oxygen saturations ≤ 92% breathing air.

Assessment should also be considered in patients with very severe airflow obstruction (FEV1 30–49% predicted).

NICE Recommendation 1.2.5.5 (CG101)

To ensure all patients eligible for LTOT are identified, pulse oximetry should be available in all healthcare settings.

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

Progress for indicator development.

Provisional indicator generated by NEC

The percentage of patients with COPD and Medical Research Council (MRC) Dyspnoea Scale ≥3 at any time in the previous 15 months and who have been offered referral to a pulmonary rehabilitation programme.

Supporting NICE recommendations for the provisional indicator taken from NICE clinical guideline 101 on COPD

NICE Recommendation 1.2.8.1 (NICE CG101)

Pulmonary rehabilitation should be made available to all appropriate people with COPD (see 1.2.8.2) including those who have had a recent hospitalisation for an acute exacerbation.

NICE Recommendation 1.2.8.2 (NICE CG101)

Pulmonary rehabilitation should be offered to all patients who consider themselves functionally disabled by COPD (usually MRC grade 3 and above). Pulmonary rehabilitation is not suitable for patients who are unable to walk, have unstable angina or who have had a recent myocardial infarction.

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

Progress for indicator development

Pre-RAND indicators

1. The percentage of patients with COPD AND Medical Research Council (MRC) Dyspnoea Scale ≥3 at any time in the preceding 15 months, with a record of oxygen saturation value within the last 15 months.

2. The percentage of patients with COPD AND Medical Research Council (MRC) Dyspnoea Scale ≥3 at any time in the preceding 15 months, with a record of oxygen saturation value within 3 months of the MRC Dyspnoea Scale ≥3.

3. The percentage of patients with COPD and Medical Research Council (MRC) Dyspnoea Scale ≥3 at any time in the preceding 15 months, with a record of a referral to a pulmonary rehabilitation programme (excluding patients on the palliative care register).

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 COPD AND Medical Research Council (MRC) Dyspnoea Scale ≥3 at any time in the preceding 15 months, with a record of oxygen saturation value within the last 15 months.

2. The percentage of patients with COPD and Medical Research Council (MRC) Dyspnoea Scale ≥3 at any time in the preceding 15 months, with a record of a referral to a pulmonary rehabilitation programme (excluding patients on the palliative care register).

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 • Women • Men
Ethnicity • Asian or Asian British • Black or black British • People of mixed race • Irish • White British • Chinese • Other minority ethnic groups not listed • Travellers
Disability • Sensory • Learning disability • Mental health • Cognitive • Mobility • Other impairment
Age[1] • Older people • Children and young people • Young adults 1. Definitions of age groups may vary according to policy or other context.
Sexual orientation & gender identity • Lesbians • Gay men • Bisexual people • Transgender people
Religion and belief
Socio-economic status 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] • Refugees and asylum seekers • Migrant workers • Looked after children • Homeless people 2. This list is illustrative rather than comprehensive.

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

Topic title: COPD
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?

Patients on the palliative care register are listed as an exclusion in COPD 2. 22 of 2532 people within the pilot practices were on both the COPD and palliative care registers. Practices felt this was an appopriate exclusion given the length of trime it can take to access services and the nature of the intervention.

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.