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

Development feedback report on piloted indicator(s)

QOF indicator area: Heart failure – cardiac rehabilitation

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 indicator

1. The percentage of patients with heart failure (diagnosed after 1 April 2011) with a record of referral for an exercise based rehabilitation programme.

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] 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

1	3	3	3

Comments	**Response**	**NHSIC Summary**
Reset indicator – date to be changed each year.	Newly diagnosed – reset every year Need to confirm.	Need to ensure this is highlighted and date updated each year.
Does a patient with newly diagnosed heart failure, who has a previous MI and a previous referral to a cardiac rehabilitation programme need to be referred for an exercise based rehabilitation programme for their heart failure? How should we approach this in the business rules?	Patients with heart failure following an MI still require referral for exercise based rehab programme. We did raise the issue at the RAND workshop but no real answer was given. In part, because Heart Failure Rehabilitation is not really widely available at the present, so many of us would not know if a post- MI rehabilitation programme would cover the necessary advice or not. The feeling was expressed that if someone had an MI and was referred for post MI rehab, then shortly after was found to have Heart Failure, the post MI advice would not cover/count towards heart failure rehab.	Business rules would need to change if opinion changes.
The business rules are looking for the latest referral for exercise based rehab programme anywhere in the record. Should this be the latest after 01//04/11? So this date would change every year too? Or Should we be looking for the referral on or after the HF diagnosis?	Look for a referral for an exercise based rehabilitation programme in the previous 15 months.	

Acceptability

General comments

Access to heart failure rehabilitation programmes across the pilot practices was very limited, leading to low levels of engagement with piloting this indicator.

Only 5 practices had access to a service. Of these, some were exercise based programmes and others were-nurse led heart failure management programmes.

Acceptability indicator 1

Practices were divided as to whether this indicator should be considered for inclusion in QOF with approximately one third supportive of its inclusion, approximately one third against its inclusion, with the remaining third being ambivalent.

Those who had access to services thought that this indicator had the potential to represent quality improvement and to be of patient benefit. Other practices felt that, as with referral to cardiac rehabilitation programmes, this was primarily a secondary care responsibility.

Practices were divided as to the best wording for this indicator if it were included in live QOF. Whilst the majority who expressed a view would prefer this indicator to read 'offered a referral' in order to support notions of patient choice and to avoid practices being disadvantaged due to non-compliant patients, they also recognised that the quality improvement was only achieved if patients actually attended.

Acceptability recommendation

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

Implementation

Assessment of piloting achievement

1. The percentage of patients with heart failure (diagnosed after 1 April 2011) with a record of referral for an exercise based rehabilitation programme.

HEART FAILURE INDICATOR	Baseline	Final
Number of Practices Uploading	**19**	**19**
Practice Population	**144,939**	**145,897**
Heart Failure Register	**1,056**	**1,083**
Excluded regardless of whether they meet Numerator criteria	*less*	*less*
Heart Failure occurred before 1st April 2011	934	965
Excluded if they do not meet Numerator criteria		
Registered within last 3 months	2	1
Heart Failure Exclusion within last 15 months	0	0
Heart Failure Exercise Exclusion within last 15 months	0	0
Heart Failure Diagnosis within last 3 months	26	28
Total Exclusions	**962**	**994**
	equals	*equals*
Heart Failure Indicator 1 Denominator	**94**	**89**
Heart Failure Indicator 1 Numerator	**0**	**1**
Numerator as % of Denominator	**0.00%**	**1.12%**

Summary

- Access to heart failure exercise based rehabilitation programmes was extremely limited which resulted in limited practice engagement when piloting this indicator.
- Practices were divided on whether this should be included in QOF with just over one third thinking it should not, a further third thinking it should, and a further third ambivalent. However these views were often based on theoretical access to services.
- Some practices felt that this was primarily a secondary care responsibility as that was where initial diagnosis tended to be made.

Changes in practice organisation

General comments

None.

Specific comments indicator 1

None.

Resource utilisation and costs

General comments

The workload associated with this indicator for practices with access to a service was minimal due to the relatively small number of people with a new diagnosis of heart failure each year that would require referral.

Specific comments indicator 1

None.

Barriers to implementation

General comments

Access to services is currently extremely limited.

Specific comments indicator 1

None.

Assessment of exception reporting

Specific comments indicator 1

Given the limited availability of services there is the potential for high levels of exception reporting using criterion I 'where an investigative or secondary care service is not available'.

Assessment of potential unintended consequences

General comments

The utility of this indicator is limited by the poor availability of services and the potential for high levels of exception reporting.

Implementation recommendation

- 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

- 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

The percentage of patients with heart failure diagnosed within the last 15 months with a record of an *offer of a referral* for an exercise based rehabilitation programme.

Guidance could suggest that this is a prospective indicator from 1.4.2013.

Appendix A: Indicator details

Recommendation(s) presented and prioritised by the Advisory Committee

Recommendation presented for potential indicator development taken from NICE clinical guideline 108 on heart failure

NICE recommendation 1.3.1.1 (NICE CG108)

- Offer a supervised group exercise-based rehabilitation programme designed for patients with heart failure.
- Ensure the patient is stable and does not have a condition or device that would preclude an exercise-based rehabilitation programme
- Include a psychological and educational component in the programme.
- The programme may be incorporated within an existing cardiac rehabilitation programme.

The conditions and devices that may preclude an exercise-based rehabilitation programme include: uncontrolled ventricular response to atrial fibrillation, uncontrolled hypertension, and high-energy pacing devices set to be activated at rates likely to be achieved during exercise.

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

Progress for indicator development.

Pre-RAND indicators

1. The percentage of patients with heart failure **(diagnosed after 1/4/2011)** who have been referred to an exercise based rehabilitation programme.

2. The percentage of patients with heart failure **(diagnosed after 1/4/2011)** with a record of referral for an exercise based rehabilitation programme.

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 heart failure (diagnosed after 1/4/2011) with a record of referral for an exercise based rehabilitation programme.

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

QUALITY AND OUTCOMES FRAMEWORK (QOF) INDICATORS EQUALITY IMPACT ASSESSMENT FORM- TOPIC SUGGESTION, PRIORITISATION, DEVELOPMENT STAGES

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: HEART FAILURE
Development stage: Piloting of indicators

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

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

None identified

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

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

None identified.

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

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

No

4. Have relevant bodies and stakeholders been consulted?

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

Yes by NICE

5. Do the indicators promote equality?

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

Not applicable to this indicator.