NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

QUALITY AND OUTCOMES FRAMEWORK (QOF) INDICATOR DEVELOPMENT PROGRAMME

Cost impact statement: Rheumatoid Arthritis

QOF indicator area: Rheumatoid Arthritis

Date: July 2012

Indicators

NM55: The practice can produce a register of all patients aged 16 years and over with rheumatoid arthritis.

NM56: The percentage of patients with rheumatoid arthritis aged 30-84 years who have had a cardiovascular risk assessment using a CVD risk assessment tool adjusted for RA in the preceding 15 months

NM57: The percentage of patients aged 50-90 years with rheumatoid arthritis who have had an assessment of fracture risk using a risk assessment tool adjusted for RA in the preceding 27 months.

NM58: The percentage of patients with rheumatoid arthritis who have had a face to face annual review in the preceding 15 months.

Introduction

This report covers 4 new indicators relating to rheumatoid arthritis (RA). These indicators are part of the NICE menu of potential Quality and Outcomes Framework (QOF) indicators for 2013/14, following the recommendations of the independent QOF advisory committee in June 2012. The indicators have been piloted as part of the NICE QOF indicator development process.

This report considers the likely cost impact of incentivising the clinical interventions associated with the proposed indicators in terms of the number of additional interventions provided and the cost of each intervention. Costs to NHS commissioners are outlined where relevant, along with the cost of additional activity at general practices.

The intent of these indicators is to establish a register of people with RA in the QOF, and to incentivise management of RA through regular review and management of risk factors.

Cost implication

Number of people affected

The NICE commissioning guide [Biologic drugs for the treatment of inflammatory disease in rheumatology, dermatology and gastroenterology](#) (2011), gives a prevalence for RA of 0.86%, which equates to around 350,000 in England.

The estimated number of people in England with RA years RA is 313,500 aged 30 to 84, and 281,700 aged 50-90 years as set out in table 1.

Table 1 Estimated number of people in England with RA by age group

Age	Population		Prevalence of RA		Number		Total
	Male	Female	Male	Female	Male	Female	
30-44	5,402,656	5,488,887	0.03%	0.18%	1,621	9,880	11,501
45-49	1,784,699	1,835,412	0.58%	1.67%	10,351	30,651	41,003
50-64	4,527,898	4,679,544	0.58%	1.67%	26,262	78,148	104,410
65-74	2,033,673	2,238,405	1.14%	2.56%	23,184	57,303	80,487
75-84	1,221,261	1,654,966	2.18%	2.99%	26,623	49,483	76,107
85-90	240,456	515,724	2.18%	2.99%	5,242	15,420	20,662
	15,210,643	16,412,938			93,283	240,887	334,170

Current care

NM55: There is currently no register for rheumatoid arthritis in the QOF. However, pilot data provided the following information:

- 23.3% of pilot practices already keep registers of people with RA.

- 36.6% noted that this clinical area related to a small number of people.

- 23.3% thought there would be an inevitable 'set-up' workload.

- 26.6% thought workload would reduce as indicators and tools became integrated.

NM56: Face to face cardiovascular risk assessment is carried out in QOF for people aged 30 to 74 with a new diagnosis of hypertension. There may be a proportion of people with RA that appear on the hypertension register and therefore that are already cared for.

NM57: There some potential overlaps between this indicator and the QOF osteoporosis indicators OST1, OST2 and OST3.

NM58: Pilot data suggest an annual review would facilitate shared decision making around treatment management and agreed outcomes. However, a number of patients with the active disease are under the care of rheumatogists.

Proposed care

NM55: In the indicator pilot, experts advised that the register should include:

- All patients who have ever had a diagnosis of 'definite' rheumatoid arthritis by a GP or a specialist, regardless of whether there was evidence of positive serology or not.

- Patients with inactive disease on treatment (that is, in remission).

- Patients with inactive disease off treatment but with evidence of past disease, such as joint deformities.

- Prospectively, patients will need a diagnosis by a specialist to be included on the register.

NM56: This indicator aims to incentivise an annual CVD risk assessment in all people on the RA register. We anticipate that the QRISK2 tool will be used because this is considered the most feasible option (other tools need a

multiplication factor to account for RA). Experts agreed that patients with existing CVD and/or familial hypercholesterolaemia should be excluded from this indicator.

NM57: This indictor incentives carrying out a fracture risk assessment every 2 years. The age range on this indicator is 50-85 years, recognising that the Qfracture tool has an age range of 30-84 years and FRAX has a range of 40-90 years. These are the tools we anticipate will be used and they give a 10 year risk of osteoporotic fracture. FRAX and QFracture can both be accessed free of charge and can also be calculated from the patient's notes. The age ranges were not included in the pilot indicator but would be for live QOF.

Further expert advice is needed about patients with a diagnosis of osteoporosis and who are currently treated with bone sparing agents.

NM58: The face to face RA annual review would be expected to cover:

- Disease activity and damage (blood tests for C-reactive protein or ESR).

- The need to organise appropriate cross referral within the multidisciplinary team.

- A discussion of DMARDS if relevant.

- The need for referral for surgery.

- The effect the disease is having on a person's life, for example employment or education.

Resource impact

NM55: There may be some initial costs to establish an RA register, such as software amendment to GP clinical information systems and initial identification of people with a diagnosis of RA, but these are not expected to be significant. The cost of maintaining the register is estimated to be negligible.

NM56: We have assumed that the CVD risk assessment will be carried out opportunistically as part of the annual RA annual review. We anticipate that the review will identify a number of people who need statin therapy. The indicator pilot health economic report assumed that that around 35% of people with RA would need satin therapy. The annual cost of satin therapy is estimated at £12 per person per year .The cost impact of this indicator is therefore calculated at £1.3 million as set out in table 2.

Table 2 Annual cost of statin therapy for people with RA

Number	CVD Risk	Number	Annual cost per patient	Total cost
313,508	35%	109,728	£12	£1,316,732

NM57: We have assumed that the fracture risk assessment is carried out opportunistically as part of the annual RA annual review. There are no data to identify further costs associated with this indicator; however, there may be some overlap with QOF osteoporosis indicators.

NM58: The feedback from the pilot suggested that a specific chronic disease clinic would be created and run by practice nurses to cover indicators NM56, NM57 and NM58 with 1 double appointment. The cost of a double appointment with a practice nurse is estimated at £25. The cost impact is estimated at £7.9 million as set out in table 3.

Table 3 Cost of a double appointment with a practice nurse

Number	Annual review	Number	Annual cost per patient	Total cost
350,000	90%	315,000	£25	£7,875,000

Sensitivity analysis

For indicator NM56 varying the CVD risk between 25% and 45% gives a cost range between £900,000 and £1.7 million.

For indicator NM58 varying the annual review numbers between 80% and 95% gives a cost range between £7 million and £8.3 million.

Unquantifiable costs

It is not possible to quantify the further costs associated with treatment for osteoporosis after an assessment for fracture risk. People who are assessed as being at risk of a fracture due to osteoporosis are likely to require a DEXA scan[1].The current cost is £69 (Department of Health, National Tariff 2012-13).

Potential savings

In the decade to 2007/08, hospital episodes for RA increased by 50% in England (Hospital Episode Statistics). More effective management (annual review) of RA may reduce hospital episodes for RA. Savings may also occur from reduced CVD events and avoided fractures for people with RA.

Conclusions

NM55: the cost of this indicator is estimated to be minimal.

NM56: the direct cost of this indicator is estimated to be £1.3million.

NM57: No direct costs of this indicator can be estimated.

NM58: the direct cost of this indicator is estimated to be £7.9 million, including opportunistic assessment of CVD risk and fracture risk.

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[1] DXA (or DEXA) stands for Dual Energy X-ray Absorptiometry. A DXA scan (also known as bone density scans or bone densitometry scans) is a type of X-ray that measures bone density. They are most commonly used to diagnose osteoporosis, but can also be used to assess the risk of osteoporosis developing.

Related QOF indicators

Current QOF indicator	Numerator	Denominator	Underlying achievement
OST1: The practice can produce a register of patients: 1. Aged 50-74 years with a record of a fragility fracture after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and 2. Aged 75 years and over with a record of a fragility fracture after 1 April 2012.	No data available – these were new QOF indicators from April 2012		
OST2: The percentage of patients aged between 50 and 74 years, with a fragility fracture, in whom osteoporosis is confirmed on DXA scan, who are currently treated with an appropriate bone-sparing agent.			
OST3: The percentage of patients aged 75 years and over with a fragility fracture, who are currently treated with an appropriate bone-sparing agent.			

References

Health and Social Care Information Centre (2011) QOF 2010/11 data [online].

University of Birmingham and University of York Health Economics Consortium Health (NICE External Contractor), Development feedback report on piloted indicators, 2012

University of Birmingham and University of York Health Economics Consortium Health (NICE External Contractor), Health economic report on piloted indicator [NM56], 2012