

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

Development feedback report on piloted indicator(s)

QOF indicator area: Rheumatoid Arthritis

Pilot period: 1st October 2011– 30th April 2012

Potential Output: Recommendations for NICE menu

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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 practice can produce a register of all patients aged 16 years and over with rheumatoid arthritis.
2. The percentage of patients with rheumatoid arthritis in whom CRP or ESR has been recorded at least once in the preceding 15 months.
3. 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 (with appropriate exclusions).
4. The percentage of patients with rheumatoid arthritis who have had an assessment of fracture risk using a risk assessment tool adjusted for RA in the preceding 15 months.
5. The percentage of patients with rheumatoid arthritis who have had a face to face annual review in the preceding 15 months.

Number of practices participating in the pilot: 34

Number of practices withdrawing from the pilot: 4

Number of practices where staff were interviewed: 30

(33 GPs, 7 Practice Nurses, 16 Practice Managers, 1 Health Care Assistant, 2 Administrative Managers = 59 primary care staff most involved in the QOF pilot)

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).

Reliability¹ and Feasibility

Indicator	Feasibility	Reliability	Implementation
1	1	1/2	1
2	1	1/2	1
3	2	2	2
4	2	2	2
5	2	2	2
GPES conversion			3

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

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

Comments	Response	NHSIC Summary
Indicator 3: Currently the only CVD risk assessment tool which adjusts for rheumatoid arthritis is QRISK2.	The codes used in the pilot for QRisk2 risk assessment exception codes are not specific enough, we will need to request new codes for exception to QRISK 2.	Codes can be requested if indicator 3 is recommended
For indicator 3 the 'appropriate exclusions' will be included in the guidance for the pilot – likely to be the current exclusions to PP1 i.e. those with CHD, diabetes, Stroke/TIA, familial hypercholesterolaemia, CKD and PVD. We could consider adding in hypertension.	Appropriate exclusions will need to be added to the business rules if this indicator goes into live QOF.	Appropriate exclusions will need to be added to the business rules if this indicator goes into live QOF. Will any of these be non QOF disease areas?
Indicator 4 has an age range of '30 to 90 years'. This information will be in the guidance for the pilot.	An age range would need to be added if this indicator goes into live QOF.	Age range will need to be appropriate for the risk assessment tool adjusted for rheumatoid arthritis
Indicator 4: The pilot used generic Osteoporosis risk assessment codes .Do we need to consider other tools (QFracture, FORE)	There weren't any available codes for other Osteoporosis risk assessments during the pilot.	If required to look for specific tests we may need to request new codes. Some tests may require a licence or incur a cost.
Indicator 5: The pilot used codes with description of 'Rheumatology disorder annual review' for rheumatoid arthritis review as these were the only available codes.	The codes used in the pilot are not specific enough, we will need to request new codes for 'rheumatoid arthritis review.'	Codes can be requested if indicator 5 is recommended.

Acceptability

General comments

Overall, this indicator area was positively received. Staff from ten practices specifically stated that this was an area that had been somewhat neglected by primary care, relative to other chronic diseases that receive greater focussed attention through their inclusion in QOF. It is, as one GP summarised:

“a very important disease, [in which] early treatment does make a difference to prognosis and the drugs that are used...have very significant side effects...It's important to identify people early, it's important to treat them promptly with the right drugs and it's important that those drugs are very carefully monitored” (GP, Practice ID: 18).

Two practices were keen to point out that their patients were *“delighted...very pleased to be focussed upon”* (PM, Practice ID: 17) and felt *“validated”* that *“somebody was taking their RA seriously”* (PN, Practice ID: 2). One third of the pilot practices also confirmed that this was a very small group of patients within the overall practice population (most cited less than 1% of the practice list size which is in line with national morbidity data)².

Approximately a third of all GPs interviewed stated that they had learnt much about increased cardiovascular and fracture risk for patients with rheumatoid arthritis through this pilot, and four of them were keen to point out the personal interest and enjoyment in clinical medicine that they gained from this. One GP extended this to the development of QOF more generally, commenting that changes in QOF enabled GPs to refresh their knowledge and reminded them of the *“joys of medicine”* (GP, Practice ID: 29).

Nearly all respondents identified potential points of overlap with secondary care in this domain, but fewer (approximately half overall) expressed any reservation about this and the majority thought it was worth working towards improved communication and co-ordination between the primary and secondary sectors to ensure good quality care. The level of concern varied with regards to specific indicators in the set. The second and forth indicators (recording CRP/ESR and fracture risk assessment scores), in particular, raised concerns about duplication (see later in the report for further detail).

Acceptability indicator 1

The overwhelming majority – 83% – of pilot practices were in favour of the creation of a register of rheumatoid arthritis patients. There was a small degree of ambivalence – 17% – but no specific objections. This reflects the positive response about the inclusion of rheumatoid arthritis as a new QOF domain in general. Those respondents that were more negative about the acceptability of rheumatoid arthritis in QOF still agreed that the register was unproblematic. This was generally seen as a necessary and logical first step if further rheumatoid arthritis indicators were to be included.

² The National Audit Office provides an estimated adult prevalence (ages 15+) of 1.4% for England which equates to an estimated number of people with rheumatoid arthritis as 580,000.

Seven practices reported that they were already keeping a register of their patients with active rheumatoid arthritis. For those that needed to create one from scratch, the task was seen as straightforward. Whether creating or revising registers, staff from eight practices stated that this gave them the opportunity to ‘clean’ or ‘tidy’ their records as they *“sifted out who wasn’t true rheumatoid”* (PM, Practice ID: 19), because there was evidence of instances where patients’ diagnoses had not been clarified or confirmed. This aligns with advice from the NICE approved experts that we consulted at the Arthritis Research UK Primary Care Centre (ARC), who recommended that patients who seem to have ‘inactive disease’ should have their diagnoses reviewed and only be included on practice registers if they have ‘definite’ rheumatoid arthritis. This would also alleviate concerns about excessively *“medicalising”* those with ‘inactive’ rheumatoid arthritis (GP, Practice ID: 29), which was raised by four practices.

Just over a quarter of respondents commented that this register (and thus the wider indicator set) could be extended to other forms of inflammatory arthritis. However, from an evidence based medicine perspective, many of the subsequent indicators only apply to people with rheumatoid arthritis. Expert advice from ARC has confirmed that the register should not include those with other diagnostic labels, such as sero-negative or psoriatic arthritis, if they do not also have a diagnosis of ‘definite’ rheumatoid arthritis.

Acceptability indicator 2 (CRP/ ESR measurement)

This indicator raised the most concern in this domain. The majority of practices (56.6%) were in favour of including this but there was also significant objection, with 26.6% of pilot practices against its inclusion. The remainder – 16.6% – were ambivalent.

The central issue was the division of labour between primary and secondary care. Nearly all the interviewees confirmed that their patients with active rheumatoid arthritis and on disease modifying drugs (DMARDs) were having their bloods checked every 2/3 months and, for the vast majority of patients (but not all), this was managed by secondary care. This could, therefore, generate two different avenues of workload: either primary care staff would duplicate work in order to have a separate annual CRP/ESR check; or administrative staff would have to spend time chasing results from secondary care to input into their clinical systems. Three respondents raised the issue that this latter avenue could mean that primary care is effectively rewarded for work conducted in secondary care (although there are precedents for this in other QOF domains), and approximately half of all practices commented that this would be an onerous task given the lack of information sharing between sectors, even for patients under shared-care arrangements.

However, those that were more positive viewed it as ‘just’ a recording issue, or worthwhile to conduct in primary care, for example:

“because the flow of information from secondary care to primary care is often sadly lacking, and we would have no guarantee whatsoever that we would get that information...it’s important that we know for our ongoing clinical care of the patients, it’s important that we have recorded in our own data what their up-to-date bloods are” (GP, Practice ID: 3).

A sixth of practices also thought it important to ensure they had the results of the CRP/ESR in order *“to know the dips or trends within the bloods that are changing”* (PN, Practice ID: 6) i.e. to have a baseline.

Acceptability indicator 3 (CVD risk assessment)

77% majority of practices were in favour of conducting a cardiovascular risk assessment for patients with rheumatoid arthritis. 20% were ambivalent and only 3% (i.e. one practice) objected to this indicator being introduced into QOF.

As mentioned above, a number of GPs were glad to have learnt about heightened cardiovascular risk in this group of patients. They were pleased at having identified patients at greater risk, viewing this as good quality preventative care. The only major concern raised was the potential for *“even ‘polier’ polypharmacy”* (GP, Practice ID: 16), though this could be addressed through appropriate exclusions (detailed further below).

Pilot practices were asked to assess cardiovascular risk using QRISK2 only. One of the Scottish pilot practices expressed a preference for ASSIGN, though it should be noted that only CV risk assessment tools adjusted for rheumatoid arthritis would be appropriate for this indicator and this does not include ASSIGN.

Acceptability indicator 4 (fracture risk assessment)

Practices were divided about the acceptability of this indicator. Whilst a majority of 57% were in favour of including this indicator in QOF, 20% were ambivalent and 23% objected to its inclusion.

As with the cardiovascular risk assessment indicator, many GPs were positive about learning about the fracture risk tool and the risk assessment scores were deemed useful for deciding whether to refer patients for DXA scans.

Much of the initial reservation around this indicator stemmed from the workload it generated during the pilot. Given that one of the assessment tools, FRAX, was not integrated into practices' clinical systems, much of the data had to be uploaded manually. Moreover, a third of the pilot practices found that they did not have the data required for this specific indicator in their patient records, which meant they needed to call patients in. It was accepted that this workload would reduce significantly if this were to become a live QOF indicator, not least because the tool would be integrated into their clinical systems by the systems suppliers but also because practices would gradually become more familiar with the tool and results.

However, overall, the 43% of practices that were ambivalent or opposed to this indicator's inclusion in QOF were still reluctant about the workload and felt that it was too specialist for primary care. Most of these practices also expressed a lack of knowledge about what to do with the risk assessment scores, other than referring patients for DXA scans or starting them on bone protection therapy.

Acceptability indicator 5 (annual review)

The final indicator in the rheumatoid arthritis set was felt to be widely acceptable. Indeed, just over half of those practices that were already keeping a register of

patients with active rheumatoid arthritis said that they were already reviewing their patients annually. Overall, 76.6% of pilot practices were in favour of including this indicator in QOF, 16.6% were ambivalent and only 6.6% of pilot practices did not think this indicator should be in QOF.

As with other indicators in this area, the ambivalent and negative responses were centred on the potential duplication of secondary care work. Specifically, it was felt that a general review of a patient with rheumatoid arthritis should fall under the jurisdiction of their rheumatologist. One GP voiced concern that patients may find such a level of care “intrusive” (GP, Practice ID: 19).

However, the majority reflected that the guidance provided by NEC for this review (focused on disease activity and medication, referrals and disease impact on the patient’s life) meant that this indicator encouraged a more generalist approach appropriate for primary care and suitably differentiated from secondary care. For example, as one GP described:

“the patients fed back to me that the rheumatologist would be very interested in joint information, disease progression, but didn’t seem to worry so much about whether the methotrexate was giving them horrible heartburn” (GP, Practice ID: 13).

Thus, the review was seen as holistic.

Five practices highlighted that the review enabled them to raise awareness around other services that may be available to patients (occupational therapists, social services). It was seen as bringing out the psychosocial elements of care that hospital specialists might not always cover. Finally, in terms of good quality primary care, a third of GPs felt that the lack of information sharing from secondary care gave them good reason to offer this holistic review and one practice added that *“it certainly improves the doctor-patient relationship”* (PM, Practice ID: 17).

Acceptability recommendation indicator 1 (register)

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

Acceptability recommendation indicator 2 (CRP/ESR measurement)

- 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.

Acceptability recommendation indicator 3 (cardiovascular risk assessment)

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

Acceptability recommendation indicator 4 (fracture risk assessment)

- 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.

Acceptability recommendation indicator 5 (annual review)

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

Implementation**Assessment of piloting achievement**

1. The practice can produce a register of all patients aged 16 years and over with rheumatoid arthritis.
2. The percentage of patients with rheumatoid arthritis in whom CRP or ESR has been recorded at least once in the preceding 15 months.

RHEUMATOID ARTHRITIS INDICATOR 502	Baseline	Final
Number of Practices Uploading	15	15
Practice Population	98,537	98,909
Patients on RA Register	650	642
Excluded if they do not meet Numerator criteria	<i>less</i>	<i>less</i>
Registered within last 3 months	2	4
Exclusion within last 15 months	0	0
Diagnosis within last 3 months	1	0
Total Exclusions	3	4
	<i>equals</i>	<i>equals</i>
RA Indicator 2 Denominator	647	638
RA Indicator 2 Numerator	351	381
Numerator as % of Denominator	54.25%	59.72%

These data reflect the qualitative interviews where GPs suggested that blood tests were already being carried out (often by secondary care).

3. 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 (with appropriate exclusions).

RHEUMATOID ARTHRITIS INDICATOR 503	Baseline	Final
Number of Practices Uploading	15	15
Practice Population	98,537	98,909
Patients on RA Register	650	642
Excluded regardless of whether they meet Numerator criteria	<i>less</i>	<i>less</i>
Patients under 30	11	13
Patients 85 or over	43	49
Excluded if they do not meet Numerator criteria		
QRISK Exception within last 15 months	0	0
Registered within last 3 months	4	5
Exclusion within last 15 months	0	0
Diagnosis within last 3 months	8	6
Total Exclusions	66	73
	<i>equals</i>	<i>equals</i>
RA Indicator 3 Denominator	584	569
RA Indicator 3 Numerator	4	46
Numerator as % of Denominator	0.68%	8.08%

These data reflect the qualitative interviews where GPs suggested that this was new work (codes did exist but were not employed until the pilot).

- The percentage of patients with rheumatoid arthritis who have had an assessment of fracture risk using a risk assessment tool adjusted for RA in the preceding 15 months.

RHEUMATOID ARTHRITIS INDICATOR 504	Baseline	Final
Number of Practices Uploading	15	15
Practice Population	98,537	98,909
Patients on RA Register	650	642
Excluded if they do not meet Numerator criteria		
Osteo Assessment Exception within last 15 months	0	2
Registered within last 3 months	5	6
Exclusion within last 15 months	0	0
Diagnosis within last 3 months	8	8
Total Exclusions	13	16
	<i>equals</i>	<i>equals</i>
RA Indicator 4 Denominator	637	626
RA Indicator 4 Numerator	0	101
Numerator as % of Denominator	0.00%	16.13%

These data reflect the qualitative interviews where GPs suggested that this was new work and despite many practices' ambivalence about the indicator, 101 people with rheumatoid arthritis were included in the numerator during the six months of the pilot.

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

RHEUMATOID ARTHRITIS INDICATOR 505	Baseline	Final
Number of Practices Uploading	15	15
Practice Population	98,537	98,909
Patients on RA Register	650	642
Excluded if they do not meet Numerator criteria		
Registered within last 3 months	5	6
Exclusion within last 15 months	0	0
Diagnosis within last 3 months	8	8
Total Exclusions	13	14
	<i>equals</i>	<i>equals</i>
RA Indicator 5 Denominator	637	628
RA Indicator 5 Numerator	0	49
Numerator as % of Denominator	0.00%	7.80%

These data reflect the qualitative interviews where GPs suggested that this was new work (new codes were requested for the pilot) and 49 people with rheumatoid arthritis were included in the numerator during the six months of the pilot.

Summary

Changes in practice organisation

General comments

Just over a third of all practices stated that they would create a chronic disease clinic specifically for rheumatoid arthritis, run by their practice nurses, if this domain were introduced into live QOF. The first four indicators were regarded as relatively straightforward because they were either administrative or automated (though better guidance was requested for the automated tools, as specified below), but the face-to-face annual review was seen as relatively time-consuming. Therefore, these practices thought it would be better to organise a specific clinic and bring the separate indicators together in one double appointment, which would also enable them to communicate the patients' risk scores to them face-to-face.

Specific comments indicator 1 (register)

None.

Specific comments indicator 2 (CRP/ESR measurement)

Just under half of all practices commented that this indicator would require administrative staff to check patients' hospital notes in order to input their blood test values in the template for rheumatoid arthritis in live QOF.

Specific comments indicator 3 (CVD risk assessment)

For those practices that would choose to run specialist nurse led clinics for people with rheumatoid arthritis (as above), those patients with high scores would be referred back to GPs.

Specific comments indicator 4 (fracture risk assessment)

Just over half of all respondents requested better guidance on fracture risk and the available tools, specifically around the interpretation of the risk scores as well as the action required. Those practices that said they would run a specialist nurse led clinic

for people with rheumatoid arthritis would need to develop specific protocols around results and refer higher risk patients back to GPs within the practice for further actions.

Specific comments indicator 5 (annual review)

Approximately a third of practices viewed this indicator as relatively time-consuming, though this was generally seen as suitable given the holistic aim of the indicator. Due to this, these practices thought it appropriate to run a separate clinic and address all the indicators together in one appointment (as above).

Resource utilisation and costs

General comments

Reflecting on workload, just under a quarter of pilot practices recognised that there would be an inevitable 'set-up' workload for these indicators, as with any new domain, but this was generally not viewed as a barrier to implementing the indicator set, particularly given the relatively small number of patients in this domain. Approximately half of all respondents commented that the subsequent actions resulting from the risk assessment tools may add to workload, but this would also reduce over time.

Specific comments indicator 1 (register)

None.

Specific comments indicator 2 (CRP/ESR measurement)

Approximately half of the practices opposed to this indicator felt that the workload in chasing CRP/ESR results from secondary care might be significant.

Specific comments indicator 3 (CVD risk assessment)

This indicator was viewed as relatively straightforward because it would be automated and is now a well recognised part of primary care.

Specific comments indicator 4 (fracture risk assessment)

There were worries about the workload entailed in manually inputting details into the fracture risk tool.

There was recognition in eight practices that it may take some time to become accustomed to calculating fracture risk scores and that this would require *"quite a change of behaviour"* (GP, Practice ID: 15). This GP drew wider comparisons: *"I think the cardiovascular risk assessments and the actions that are generated by that are quite deeply embedded now whereas I think...well, certainly my FRAX is not embedded"* (GP, Practice ID: 15).

Specific comments indicator 5 (annual review)

There was some concern about the time that this indicator would take, though a third of the pilot practices had developed a strategy to manage this (in the form of a specialist clinic, as detailed above).

Barriers to implementation

General comments

None not already highlighted earlier in the report.

Specific comments indicator 1(register)

None not already highlighted earlier in the report.

Specific comments indicator 2 (CRP/ESR measurement)

None not already highlighted earlier in the report.

Specific comments indicator 3 (CVD risk assessment)

None not already highlighted earlier in the report.

Specific comments indicator 4 (fracture risk assessment)

None not already highlighted earlier in the report.

Specific comments indicator 5 (annual review)

None not already highlighted earlier in the report.

Assessment of exception reporting

Specific comments indicator 1 (register)

None.

Specific comments indicator 2 (CRP/ESR measurement)

None.

Specific comments indicator 3 (CVD risk assessment)

It would be appropriate to exclude from the denominator those patients with pre-existing cardiovascular disease as with CVD-PP1³. Therefore patients with the following conditions would be excluded from this indicator:

- coronary heart disease or angina

³ 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 aged 30 to 74 years who have had a face to face cardiovascular risk assessment at the outset of diagnosis (within 3 months of initial diagnosis) using an agreed risk tool.

- stroke or TIA
- peripheral vascular disease
- familial hypercholesterolemia
- diabetes
- chronic kidney disease where the patient has an eGFR value of below 60
- those aged less than 30 or over 84 years old.

Consideration will also need to be given as to how to manage patients already identified as having an elevated cardiovascular risk. Should this indicator be recommended for live QOF the NEC will explore with the IC whether this group of patients can be excluded via the business rules or whether they would need to be exception reported.

Specific comments indicator 4 (fracture risk assessment)

One GP thought it was appropriate to exclude those already on biphosphonates as well as patients that had had a DXA scan in the last 12 months (GP, Practice ID: 5).

Should this indicator be recommended for inclusion in live QOF, further expert clinical opinion will be sought as to whether patients with a diagnosis of osteoporosis or currently being treated with bone sparing agents should be treated as exclusions to this indicator.

Specific comments indicator 5 (annual review)

None.

Assessment of potential unintended consequences

General comments

None

Implementation recommendations

Implementation recommendation indicator 1(register)

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

Implementation recommendation indicator 2 (CRP/ESR measurement)

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

Implementation recommendation indicator 3 (CVD risk assessment)

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

Implementation recommendation indicator 4 (fracture risk assessment)

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

Implementation recommendation indicator 5 (annual review)

- 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

CVD-PP1: 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 aged 30 to 74 years who have had a face to face cardiovascular risk assessment at the outset of diagnosis (within 3 months of the initial diagnosis) using an agreed risk assessment tool.

There is some overlap between this indicator and pilot indicator 3 (CVD risk assessment). It is recommended that the same exclusions in terms of pre-existing diagnoses are applied to the pilot indicator in live QOF, with the addition of hypertension.

The AC is asked to note the difference in age ranges for CVD-PP1 and the piloted indicator.

There are also some potential overlaps between the Osteoporosis: secondary prevention of fragility fracture domain and pilot indicator 4 (fracture risk assessment).

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 fragility fracture after 1 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.

As discussed above further expert clinical advice will be sought as to whether patients with a diagnosis of osteoporosis or being treated with bone sparing agents should be treated as exclusions to pilot indicator 3.

Most overall recommendations are amber, reflecting the amber implementation issues, but it should be noted that indicators 3 and 5 were viewed positively by a majority of practices in the pilot and the implementation issues can be relatively easily addressed for live QOF.

Overall recommendation indicator 1 (register)

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

Overall recommendation indicator 2 (CRP/ESR measurement)

- 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.

Overall recommendation indicator 3 (CVD risk assessment)

- 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.

Overall recommendation indicator 4 (fracture risk assessment)

- 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.

Overall recommendation indicator 5 (annual review)

- 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 1 (register)

The NEC has been advised that the register should only include patients with a 'definite' diagnosis of rheumatoid arthritis, regardless of evidence of positive serology and current 'activity' status. Patients who appear to have 'inactive disease' should have the rheumatoid arthritis diagnosis reviewed by a specialist as the original diagnosis may have been incorrect. Where this is the case then this should be recorded in the patient's record and they should be removed from the register.

Suggested amendments to indicator 2 (CRP/ESR measurement)

No suggested amendments.

Suggested amendments to indicator 3 (CVD risk assessment)

No suggested amendments. Exclusions of patients with pre-existing cardiovascular disease or already recognised as being at high risk will be addressed through the QOF Guidance and associated business rules.

Suggested amendments to indicator 4 (fracture risk assessment)

The NEC has been advised that forthcoming NICE guidance is likely to recommend recalculating fracture risk only after a minimum of two years and if the original calculated risk was close to the intervention threshold for a proposed treatment, or

when there has been a change in the person's risk factors. Given this, the following amendment is recommended to the AC subject to confirmation from NICE that this is consistent with their guidelines when published:

*The percentage of patients with rheumatoid arthritis who have had an assessment of fracture risk using a risk assessment tool adjusted to include RA in the preceding **24 months**.*

Suggested amendments to indicator 5 (annual review)

The AC may want to consider including the CRP/ESR recommendation as part of the annual review.

Appendix A: Indicator details

Recommendation(s) presented and prioritised by the Advisory Committee

The NEC stated that the proposed indicators had some definitional issues that would require resolution but were feasible. The Committee agreed that this was an area of quality improvement in primary care.

NICE clinical guideline recommendations

NICE recommendation 1.5.1.1

Measure CRP and key components of disease activity (using a composite score such as DAS28) regularly in people with rheumatoid arthritis to inform decision-making about:

- increasing treatment to control disease
- cautiously decreasing treatment when disease is controlled.

NICE recommendation 1.5.1.4

Offer people with rheumatoid arthritis an annual review to:

- assess disease activity and damage, and measure functional ability (using, for example, the Health Assessment Questionnaire [HAQ])
- check for the development of co morbidities, such as hypertension, ischaemic heart disease, osteoporosis and depression
- assess symptoms that suggest complications, such as vasculitis and disease of the cervical spine, lung or eyes
- organise appropriate cross referral within the multidisciplinary team
- assess the need for referral for surgery
- assess the effect the disease is having on a person's life.

Summary of Committee considerations (taken from the June 2011 Committee minutes)

The Committee recommended that the topic of rheumatoid arthritis should be progressed for indicator development. The development of a register of people with rheumatoid arthritis with an annual review component. Indicator development to consider both bundled and unbundled approaches to the annual review. Indicator development to take in to account recommendations 1.5.1.4 and 1.5.1.1 as outlined in the briefing paper on rheumatoid arthritis. Indicator development to consider whether rapid assessment for DMARDS is feasible – either as a separate indicator or as part of the annual review indicator.

Pre-RAND indicators

1. The practice can produce a register of all patients aged 16 years and over with rheumatoid arthritis
2. The percentage of patients with rheumatoid arthritis in whom CRP or ESR has been recorded at least once in the preceding 12 months
3. <i>The percentage of patients with rheumatoid arthritis in whom CRP or ESR has been recorded at least once in the preceding 15 months⁴</i>
4. The percentage of patients with rheumatoid arthritis aged 30-84 years who have had a cardiovascular risk assessment using QRISK2 in the preceding 12 months
5. <i>The percentage of patients with rheumatoid arthritis aged 30-84 years who have had a cardiovascular risk assessment using QRISK2 in the preceding 15 months (with appropriate exclusions)</i>
6. The percentage of patients with rheumatoid arthritis aged 40-90 years who have had a FRAX score calculated in the preceding 12 months
7. <i>The percentage of patients with rheumatoid arthritis aged 40-90 years who have had a FRAX score calculated in the preceding X months</i>
8. The percentage of patients with rheumatoid arthritis who have had a face to face annual review in the preceding 12 months
9. <i>The percentage of patients with rheumatoid arthritis who have had a face to face annual review in the preceding 15 months</i>

Final indicators as piloted

1. The practice can produce a register of all patients aged 16 years and over with rheumatoid arthritis
2. The percentage of patients with rheumatoid arthritis in whom CRP or ESR has been recorded at least once in the preceding 15 months
3. 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 (with appropriate exclusions)
4. The percentage of patients with rheumatoid arthritis who have had an assessment of fracture risk using a risk assessment tool adjusted for RA in the preceding 15 months
5. The percentage of patients with rheumatoid arthritis who have had a face to face annual review in the preceding 15 months.

⁴ Indicators in italics text reflect modifications to wording made by the panel during round 2. Primary Care Quality and Outcomes Framework Indicator Advisory Committee 13th and 14th June 2012
Agenda item 18.4: Rheumatoid arthritis

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

CENTRE FOR CLINICAL PRACTICE

Quality and Outcomes Framework Programme

QOF topic: Rheumatoid arthritis

Output: Recommendations for the NICE menu

Introduction

1. As outlined in the QOF process manual, NICE has a duty to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations between people from different groups. The purpose of this form is to document the consideration of equality issues in **each stage** of the development process before reaching the final output that will be approved by the NICE Guidance Executive. This equality analysis is designed to support compliance with NICE's obligations under the Equality Act 2010 and Human Rights Act 1998.
2. Table 1 lists the equality characteristics and other equality factors NICE needs to consider, i.e. not just population groups sharing the 'protected characteristics' defined in the Equality Act but also those affected by health inequalities associated with socioeconomic factors or other forms of disadvantage. Taking into account each of the equality characteristics in Table 1, the form should be used to:
 - confirm that equality issues have been considered
 - ensure that the indicator statements do not discriminate against any of the equality groups
 - highlight planned action relevant to equality
 - highlight areas where indicator statements may advance equality of opportunity
3. This form is completed by the NICE quality systems team and will be completed at each stage within the development process:
 - Prioritisation of areas for new indicator development
 - Piloting of indicators
 - Public consultation of piloted indicators
 - Review of existing indicators in the clinical domains

The initial prioritisation may identify equalities associated with a topic area whereas piloting and consultation will assess equalities against specific indicators. For further

information on the development of specific indicators please refer to the [committee outputs](#) page and the [NICE menu of indicators](#).

Table 1

Protected characteristics
Age
Disability
Gender reassignment
Pregnancy and maternity
Race
Religion or belief
Sex
Sexual orientation
Other characteristics
Socio-economic status Depending on policy or other context, this may cover factors such as social exclusion and deprivation associated with geographical areas or inequalities or variations associated with other geographical distinctions (e.g. the North/South divide, urban versus rural).
Other categories Other groups in the population experience poor health because of circumstances often affected by, but going beyond, sharing a protected characteristic or socioeconomic status. Whether such groups are identifiable depends on the guidance topic and the evidence. The following are examples of groups covered in NICE guidance: • Refugees and asylum seekers • Migrant workers • Looked after children • Homeless people.

QOF equality analysis form

Development stage: Piloting of indicators

Indicator title: Rheumatoid arthritis

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. Have relevant bodies and stakeholders been consulted, including those with a specific interest in equalities? Have comments highlighting potential for discrimination or advancing equality been considered?
Not relevant at this stage
3. Have any population groups, treatments or settings been excluded at this stage in the process? Are these exclusions legal and justified? Are the reasons for justifying any exclusion legitimate?
The register excludes people aged less than 16 years because RA is rare under this age and is then largely treated by specialists rather than in primary care. The CRP/ESR indicator, as piloted also excludes people younger than 16 years for the same reasons as above. The RA CVD risk assessment indicator, as piloted, focuses on people aged 30-84 years (in line with the evidence base). The RA fracture risk assessment indicator excludes patients on the RA register aged under 30 years and over 90 years (in line with the evidence base).
4. Do any of the indicators 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?
None identified at this stage.
5. Do the indicators advance equality? Please state if the indicator as described will advance equalities of opportunity, for example by making access more likely for certain groups, by tailoring the service to certain groups, or by making reasonable adjustments for people with disabilities?
RA affects three times as many women as men and has a peak age of onset of 40-70 years. They also have reduced life expectancy. The RA CVD indicator promotes the use of risk assessment tools which appropriately adjust the resulting risk score for people with RA.

Osteoporosis is more common in people with RA. The fracture risk assessment indicator promotes the use of fracture risk assessment tools which appropriately adjust the resulting risk score for people with RA.