UNIVERSITY OF MANCHESTER NATIONAL PRIMARY CARE RESEARCH AND DEVELOPMENT CENTRE AND UNIVERSITY OF YORK HEALTH ECONOMICS CONSORTIUM (NICE EXTERNAL CONTRACTOR)

Development feedback report on piloted indicator(s)

QOF indicator area: Diabetes: structured education and dietary review

Pilot period: 1st October 2010 – 31st March 2011

Potential output: Recommendations for NICE Menu

Contents

Piloted indicator(s)

Diabetes: Structured Education Programme

1. The percentage of patients newly diagnosed with diabetes (as of 1 October 2010) who have a record of being referred to a structured education programme within 3 months of entry on to the diabetes register.

Diabetes: Dietary Review

2. The percentage of patients with diabetes who have a record of a dietary review by a suitably competent professional in the previous 15 months.

Number of practices participating in the pilot:	30
Number of practices withdrawing from the pilot:	3[1]
Number of practices where staff were interviewed:	29

Assessment of clarity, reliability, acceptability, feasibility, and implementation

Clarity

- Indicator wording 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)

[1] 3 practices withdrew late in the pilot. 2 were still able to give comments about the indicators.

Reliability[2] and Feasibility

Indicator	Feasibility	Reliability	Implementation
1	2	3	2
2	2	3	2

Comments	Response	NHSIC Summary
1) How will the usual 3 month exception for unsuccessful patients operate? Patients diagnosed from 1 Jan 2012 until 31 March 2012 will either be a success of be excepted	3 month issue was to be brought up at the Ops Board	Reset indicator Possible cross year considerations
How are different types of diabetes handled		Need to ensure guidance and correct read code choice are well explained
What constitutes structured education – can it be in-house?		Need to ensure guidance and correct read code choice are well explained.
2) Suitable competent professional?		Need to ensure guidance and correct read code choice are well explained.

Acceptability

General comments

Diabetes was seen as a very important part of primary care and of QOF and both of these indicators were generally seen as acceptable.

Specific comments indicator 1 (SE)

All practices were positive about this indicator *"easy to meet and clinically meaningful"*; with only two expressing any sense of ambivalence related to the fact that they had been doing this for years and therefore they felt it was *"a waste of QOF*

[2] 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

points." It should be noted that most other practices also stated that this indicator represented little in the way of new work but this did not stop them from recommending it going forwards.

Almost all felt three months was an appropriate time frame (three practices thought it should be six months).

All felt that the indicator should focus on referral rather than attendance or completion.

Patient feedback about this indicator was generally positive.

Specific comments indicator 2 (DIET)

Almost all practices were positive about this indicator and said they were *"already doing it so it's a very cheap point."*

Almost all practices felt that a practice nurse who had been on a diabetes training course was a *'suitably competent professional'.*

Only two expressed any sense of ambivalence, one related to the fact that their practice nurse had not been trained up to the standard that they felt made her a 'suitably competent professional' in the indicator wording, and the other because he felt this indicator should mean a referral to a dietician which would not be possible in their practice area (too few dieticians and very long waiting lists with tight referral criteria).

The lack of availability of dieticians or possibility of referring outside the practice for this indicator was echoed by nearly every practice.

All felt this should be an annual indicator and would become part of their diabetes annual review template.

All felt patients liked getting dietary advice from the practice and saw it *"as part of the package of having diabetes."* However there was less agreement over what constitutes a dietary review between practices, with most GPs feeling that it had pragmatically to be whatever a well trained PN had learnt about on their diabetes course.

Acceptability recommendation for SE

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 the indicator from being recommended for publication on the NICE menu of indicators.

Acceptability recommendation for DIET

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 the indicator from being recommended for publication on the NICE menu of indicators.

Implementation

Assessment of piloting achievement

Diabetes: Structured Education Programme

The percentage of patients newly diagnosed with diabetes (as of 1 October 2010) who have a record of being referred to a structured education programme within 3 months of entry on to the diabetes register.

	Baseline	**Final**	**Number of practices uploading data at both baseline and final**
Population	139561	147152	
Number of practices uploading data	16	18	16
Mean practice denominator[3] i.e. people eligible for SE	10.9 (175)	5.1 (92)	
Mean practice numerator	1.06 (17)	2.06 (37)	
Mean score[4]	9.7%	40.2%	

The timeframe for the baseline upload was 12m and for the final upload was 6m.

Please note that the population is people with newly diagnosed diabetes.

Assessment of piloting achievement

Diabetes: Dietary Review

The percentage of patients with diabetes who have a record of a dietary review by a suitably competent professional in the previous 15 months.

	Baseline	**Final**	**Number of practices uploading data at both baseline and final**
Population	139561	147152	

[3] The average number of people across practices eligible for inclusion in the indicator population
[4] The average achievement across practices for the indicator

Number of practices uploading data	16	18	16
Mean practice denominator[5] i.e. people with diabetes eligible for a dietary review	146.8 (2349)	197 (3546)	
Mean practice numerator	0	4.33 (78)	
Mean score[6]	0	2.2%	

The timeframe for the baseline upload was 12m and for the final upload was 6m.

72 patients were from the same practice in the final upload.

Summary:

Practices did not appear to be routinely recording a referral of people to structured education programmes pre pilot but did so during the pilot more consistently leading to a much greater % (40.2% cf 9.7%) at the end of the pilot.

Almost all practices did not record a dietary review in a separate manner because they felt this was a routine part of the practice nurse diabetes annual review and not a separate issue. There would therefore be a significant education and template issue if this indicator became part of live QOF.

Changes in practice organisation

Specific comments indicator 1(SE)

Since practices tended to refer out where possible, there were few changes to practice organization. Where practices provided education in house, this was a continuation of previous practice.

Specific comments indicator 2 (DIET)

Dietary review was not routinely recorded (see above.)

Resource utilisation and costs

Specific comments indicator 1(SE)

40% of practices provided in house structured education with well trained practice nurses but if DESMOND/DAFNE was available locally, most would have preferred to refer to those services.

Specific comments indicator 2 (DIET)

A number of practices noted that DESMOND includes dietary advice and therefore this indicator duplicates elements of the structured education indicator.

[5] The average number of people across practices eligible for inclusion in the indicator population
[6] The average achievement across practices for the indicator

Barriers to implementation

Specific comments indicator 1(SE)

60% of practices were able to refer to local DESMOND schemes for people with type 2. DAFNE schemes appeared less widely available for people with type 1 diabetes. There was also a general agreement that people with type 1 diabetes were referred or seen and advised by secondary care services.

Funding restrictions in one area had led to the closure of a local DESMOND scheme in one area.

Five practices in areas with larger BME communities raised the issue of lower attendance rates of their Asian patients at DESMOND schemes and the questioned the cultural sensitivity of the schemes.

If practices were unable to refer to DESMOND and this indicator became part of live QOF, then practices felt that their practice nurses would need particular training around diets in different cultures and also need to have interpreters readily available for practice education sessions.

Specific comments indicator 2 (DIET)

Referring to dieticians was not a viable option and therefore guidance would need to be explicit about the training requirements expected for practice nurses undertaking this task.

Assessment of exception reporting

Specific comments indicator 1(SE)

A minority of practices highlighted the problem of younger people who were working who might not have 1.5 days available to attend a DESMOND course. (However since the indicator at present is referral, this may not affect exception reporting).

Specific comments indicator 2 (DIET)

Three practices expressed a concern that elderly patients might be more likely to be exception reported from the indicator.

Two practices felt that pregnant women should be excluded from this indicator since they would receive advice as part of their antenatal care.

Assessment of potential unintended consequences

Specific comments indicator 1(SE)

There is likely to be significant variation in how practices approach this indicator in live QOF depending on the availability of DESMOND/DAFNE or equivalent schemes.

Specific comments indicator 2 (DIET)

Practitioner health!! One practice noted that it would be difficult for their overweight practice nurses to give detailed dietary advice to patients with diabetes…and that *"GPs with tubby tummies can hardly sit there and tell patients to cut back on their carbohydrates!"*

Implementation recommendation for SE

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 for DIET

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

Specific comments indicator 1 (SE)

QOF guidance for Diabetes (DM) indicator 26 (NICE menu NM14) includes “Offer structured education to every person and/or their carer at and around the time of diagnosis, with annual reinforcement and review. Inform people and their carers that structured education is an integral part of diabetes care.”

However there is no indicator at the moment that would need to be directly modified.

Specific comments indicator 2 (DIET)

QOF guidance for Diabetes (DM) indicator 26 (NICE menu NM14) includes “Provide individualised and ongoing nutritional advice from a healthcare professional with specific expertise and competencies in nutrition”. This may also help explain the lack of individual separate recording of the dietary review.

There is a potential overlap with the indicator on structured education for people with diabetes, as structured education should include diet and nutritional advice. However the overlap is small and for one year only.

Overall recommendation for structured education

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 for dietary 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

If the SE indicator is to be non cumulative, it should be phrased as follows:

The percentage of patients newly diagnosed with diabetes in the preceding 12 months who have a record of being referred to a structured education programme within 3 months of entry on to the diabetes register.

There are potential problems with timeframes in that most practitioners felt that 3 m was appropriate for people with type 2 but stakeholders have suggested that DAFNE for type 1 diabetes recommends a minimum wait for referral of 6 months diagnosis. It may be best to ensure guidance is clear about different expectations depending on the diagnosis, but to therefore change the wording as follows:

The percentage of patients newly diagnosed with diabetes in the preceding 12 months who have a record of being referred to a structured education programme within 9 months of entry on to the diabetes register.

Appendix A: Indicator details

Recommendation(s) presented & prioritised by the Advisory Committee

Diabetes structured patient-education

Technology Appraisal 60: Diabetes (types 1 and 2) - patient education model

1.1 It is recommended that structured patient education is made available to all people with diabetes at the time of initial diagnosis and then as required on an ongoing basis, based on a formal, regular assessment of need.

1.4 It is considered that the Dose Adjustment for Normal Eating (DAFNE) programme may be a suitable option for individuals with type 1 diabetes, being one means of enabling people to self-manage this condition.

Diabetes dietary review

NICE clinical guideline 15 (Type 1 Diabetes in adults)	NICE recommendation 1.8.3.1 Nutritional information sensitive to personal needs and culture should be offered from the time of diagnosis of Type 1 diabetes.
NICE clinical guidance 66 (Type 2 Diabetes)	NICE recommendation 8 Provide dietary advice in a form sensitive to the individual's needs, culture and beliefs being sensitive to their willingness to change, and the effects on their quality of life (Type 2 Diabetes)
SIGN clinical guidance 116	SIGN recommendation 3.7.1

Summary of Committee considerations (taken from the Committee minutes)

Diabetes structured patient-education

The Committee was asked to consider information presented in a briefing note on the topic of structured patient-education for diabetes. The Committee noted that it had previously considered this topic for indicator development but had not made a recommendation to proceed to indicator development due to concerns about the availability of services across the UK, and concerns about how the evidence base relates to those minority ethnic groups where the prevalence of diabetes is significantly higher than in the general population.

The Committee noted that the position statement, previously agreed by the Committee, outlines that uncertainty about universal coverage of services should not be a barrier to indicator development. The Committee noted that

structured patient-education programmes are considered to be clinically and cost effective.

The Committee noted that no evidence was found to suggest that structured patient-education programmes were of less benefit or less acceptable to people from differing ethnic backgrounds.

The Committee noted that structured patient-education programmes had been adapted, in accordance with NICE guidelines, to the needs of differing ethnic minority groups and that these programmes had been rolled out across Primary Care Trusts.

The Committee considered whether indicator development should focus on those newly diagnosed with diabetes or people with established diabetes.

The Committee agreed that indicator development should focus on those newly diagnosed as outlined in recommendation 1.1.1 from the clinical guideline on type 2 diabetes.

The Committee agreed that both type 1 and type 2 diabetes should be covered by developed indicators.

The Committee considered whether indicator development should focus on referral only and whether attendance and /or completion of structured patient-education programmes should be incentivised.

The expert technical advisor (ETA) stated that there would be technical challenges to indicators that incentivised attendance and/or completion of structured patient-education programmes.

The ETA also advised that there would need to be clear advice or guidance as to what constitutes structured patient-education programmes.

The Committee agreed that the indicator development process would explore concepts such as ‘referral ’, ‘attended’ and ‘completion’.

The Committee recommended that the topic of structured patient-education for diabetes should be progressed for indicator development.

Diabetes dietary review

The Committee considered a briefing paper, including an Equalities Impact Assessment form, on the topic of diabetes dietary review. The Committee agreed that dietary review was an important area but had concerns about who would provide the review. The Committee agreed that this could be explored as part of indicator development. The ETA advised that indicator development on this area would not be problematic, if there was guidance as to who could provide the dietary/nutritional advice. The Committee noted that there could be an overlap with the indicator on structured education for people with diabetes, as structured education would include diet and nutritional advice.

The Committee noted that the NICE clinical guideline 87 on type 2 diabetes states that structured education should be followed by ‘annual reinforcement

and review' and that indicators on dietary review could be part of the 'annual reinforcement and review'.

NICE clinical guideline 15: recommendation 1.8.3.1	Recommend to progress for development
NICE clinical guidance 66: recommendation 8	Recommend to progress for development
SIGN clinical guidance 116: recommendation 3.7.1	Recommend to progress for development

Pre-RAND indicators

Diabetes: Structured Education Programme

1. The percentage of patients newly diagnosed with diabetes (as of 1 October 2010) who have a record of being offered referral to a structured education programme within 3 months of entry on to the diabetes register
2. The percentage of patients newly diagnosed with diabetes (as of 1 October 2010) who have a record of being referred to a structured education programme within 3 months of entry on to the diabetes register
3. In patients newly diagnosed with diabetes (as of 1 October 2010) who have a record of referral to a structured education programme within 3 months of entry on to the diabetes register, the percentage of patients with a record of attendance at the structured education programme
4. In patients newly diagnosed with diabetes (as of 1 October 2010) who have a record of referral to structured education programme within 3 months of entry on to the diabetes register, the percentage of patients with a record of completion of the structured education programme

DOMAIN 1 (continued): DIABETES

(Diabetes: Diet)

1. The percentage of patients with diabetes who have a record of a dietary review by a suitably competent professional in the previous 15 months
2. The percentage of patients with diabetes who have a record of a dietary review in the previous 15 months
3. The percentage of patients with newly diagnosed diabetes (as of 1 October 2010) who have a record of a dietary review by a suitably competent professional within 3 months of entry on to the diabetes register

4. The percentage of patients with newly diagnosed diabetes (as of 1 October 2010) who have a record of a dietary review within 3 months of entry on to the diabetes register
5. The percentage of patients with newly diagnosed type 1 diabetes (as of 1 October 2010) who have a record of a dietary review by a suitably competent professional sensitive to personal needs and culture within 3 months of entry on to the diabetes register
6. The percentage of patients with newly diagnosed type 2 diabetes (as of 1 October 2010) who have a record of a dietary review by a suitably competent professional sensitive to personal needs and culture within 3 months of entry on to the diabetes register
7. The percentage of patients with newly diagnosed type 1 or type 2 diabetes (as of 1 October 2010) who have a record of a dietary review by a suitably competent professional sensitive to the individual's needs, culture and beliefs and their willingness to change, and the effects on their quality of life

Final indicators as piloted

Diabetes: Structured Education Programme

The percentage of patients newly diagnosed with diabetes (as of 1 October 2010) who have a record of being referred to a structured education programme within 3 months of entry on to the diabetes register.

Diabetes: Dietary Review

The percentage of patients with diabetes who have a record of a dietary review by a suitably competent professional in the previous 15 months

Appendix B: Details of assessment criteria for piloted indicators

This appendix provides details for each of the assessment criteria used in the report to provide the basis of the pilot feedback, assessments and recommendations.

Clarity

Clarity measures whether the indicator wording is clear and unambiguous. This is assessed and rated by the RAM[7] panel, in terms of the ability to write business rules (and/or an extraction specification) for the indicator. Clarity may also take into account the attribution of the indicator, that is whether it is applicable to primary care and performed within the practice.

Reliability

Reliability measures how closely multiple formats or versions of an indicator produce the same result. Each indicator undergoes compulsory reliability testing (how closely multiple versions of a test produce the same result).

Data elements obtained through automated search strategies of electronic health records are verified against and compared with a reference manual review strategy for obtaining the data elements, and a report is compiled. Reasons for any discrepancies between electronic extraction and manual reviews are then investigated and documented. This procedure is undertaken for each indicator in a small number of practices.

During the analysis, development and execution of the extraction software, issues are documented and a statement on the level of change required to subsequent business rules is prepared.

Acceptability

Acceptability measures how acceptable the activity is to both the assessors and those being assessed, for example that the activity is perceived as good clinical practice without any major barriers, risks or issues. Assessment might examine any conflicts with national guidance, variation in preferences of engagement with patients, concerns in relation to exception reporting, frequency of prescribing or undue focus on one area of care.

Feasibility

Feasibility measures the ability of the clinical practice to interpret an indicator's definitions and technical specifications and integrate them into both clinical practice and health information systems, and generate performance

[7] In the initial stages indicators in development go through a rigorous two-stage consensus process: a modified RAND/UCLA Appropriateness Method (RAM). This is the only systematic method of combining expert opinion and evidence (Naylor, 1998) and feeds consultation with experts in each clinical area as appropriate in to the development process.

reports within a reasonable time frame and budget. A technical feasibility assessment will include the ability to extract data from the pilot practices using business rules, and/or an extraction specification via an extraction software provider (PRIMIS+) at the appropriate times, using the technical solution for each extract.

Assessment will also include an outline of any exception reporting codes necessary or subsequent changes to the business rules for indicators to operate functionally in live QOF.

Implementation

Implementation measures several factors which may have an impact on a practice and/or patient during the piloting of an indicator.

An assessment of piloting achievement measures the current baseline and any changes in baseline including the degree of confidence that the baseline is representative of the expected national baseline. The assessment will also report if the baseline has been supplemented with GPRD/THIN[8] data.

Changes in practice organisation measures any necessary changes required to create, use, and maintain the capacity to report on an indicator. These changes might involve IT, staffing, workflow structure, processes, policies, culture, inter-organisational relationships, and physical or financial capital critical to the cost effectiveness analysis.

Resource utilisation and costs measures the resource impact the indicator has on a practice. This may require engagement and consultation with practices through qualitative face-to-face methods, for example work load diaries, interviews and focus groups or quantitative methods exploring the extracted data from the piloted indicators.

Barriers to implementation measure any major barriers which would make the indicator unreasonably difficult to implement in practices or in live QOF. This may include requirements to make fundamental changes to practice organisation, unfeasible data collection or any unacceptable impact of unintended consequences. Assessment might examine barriers encountered in data collection, whether there was a lack of existing templates, the completeness of data and any missing data, and whether the indicator requires the reporting of new data items or concepts that are not routinely captured as part of current practice.

The implementation assessment will also take into account the overlap with existing indicators, and the extent of any overlap. For instance, whether the indicator partly or completely duplicates activities covered by other indicators in the same or a separate clinical domain.

[8] The Health Improvement Network (THIN) is a partnership of organisations which develop primary care systems. The general practice research database (GPRD), developed by THIN, is a database of anonymised patient records from information entered by general practices in their clinical systems.

An assessment of exception reporting measures the susceptibility of an indicator to high levels of exception reporting. This may include engagement issues, relevance of the indicator to certain groups, contraindications, and the accessibility of patients (namely those who are housebound or in a nursing home). The rate of exception reporting for the piloted indicator will include the extent to which exception reporting levels are within the expected range.

Unintended consequences are unforeseen effects of QOF measurements on processes of care, patient outcomes, and/or the functioning of the wider healthcare system. They may be positive in nature, for example encouraging general quality improvement, or negative, such as diversion of effort, disruption to clinical or organisational workflows, susceptibility to monetary gain, potential harm to patients, inappropriate standardisation of care or local practice, and undue focus on process. This may require auditing of patient exception reporting and referral rates to other health and social care sectors, and exploration of the reasons for these at an individual level including patient socio-demographic variables if available.