

National Institute for Health and Care Excellence

NICE Indicators Consultation

Closing date: 5pm – 23rd February 2015

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Please note: comments submitted on draft indicators are published on the NICE website.	

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Please provide comments on the draft indicators on the form below, putting each new comment in a new row. Please note the indicator or measure that you are commenting on in the 'ID' column.

In order to guide your comments, please refer to the general points for consideration on the NICE website as well as the specific questions detailed within the consultation paper.

Please add rows as necessary.

Indicator / measure ID	Comments
QOF Indicator 1	<p>The evidence that they have poor cardiovascular health is established. In answer to the first question we don't think that a specific indicator will add very much to the cardiovascular health of this group. GPs lack evidence based interventions and resources to help all patients deal with problems of weight, and we would expect that this may be more challenging with this group than others.</p> <p>However there is a concern that GPs will focus on cardiovascular risk to the detriment of discussing patients' mental health (because it is easier to manage in a mechanistic way). What, if they have no increased risk, is the rationale that it has to be repeated annually?</p> <p>Care planning and understanding the patient's priorities and expectations is key here. The specific and explicit requirement that we should be being asked to deal with for this group is trying our hardest to enable them to enjoy life more, not to enable it to continue unhappily.</p> <p>These patients should be considered for sexual health-contraception, sexually acquired infections, unwanted pregnancy, immunisation HPV/Rubella, screening for Chlamydia and help with psychosexual problems as they are vulnerable.</p> <p>Risk assessment does not equate to service provision to tackle increased risks, which may not be as readily accessible to people with severe mental illness compared to other people. Weight management services are not uniformly available in different localities and currently severe mental illness would be a probable exclusion criteria for bariatric surgery. Meanwhile, comprehensive support through a tier 3 obesity service is not widely available and the embryonic services that are developing may not have the capacity to help patients with more diverse and specialised needs. These issues would need consideration if this indicator is to avoid highlighting a gap in the ability of those with severe mental illness to access appropriate lifestyle support.</p>

Indicator / measure ID	Comments
QOF Indicator 2	<p>We all recognise the problems of obesity, and the conditions seem (mostly) appropriate. But again, what is the rationale that this must be done every year? People tend to stay normal weight or overweight for quite long periods of time. More importantly, doctors lack the evidence based tools and resources to make them effective in helping patients to lose weight. GPs may have a small role to play, but the national problem will only be dealt with by national public health policies on food, eating, transport, sport etc. This indicator could be very divisive as it may induce a sense of failure among patients and doctors, and possibly antagonistic relationships between them.</p> <p>The list of chronic diseases should also include liver disease, as non-alcoholic fatty liver disease is an increasingly common condition that predisposes to NASH and cirrhosis.</p>
QOF Indicator 3	<p>This seems to amount to an amalgamation of work already being done: is this the intention?</p> <p>These patients should also be considered for pneumococcal vaccine.</p> <p>Is there a reason why the chronic diseases listed in the obesity indicator differ from the immunisation list?</p>
QOF Indicator 4	<p>We are delighted that the problem of polypharmacy is being recognised. We are, however, puzzled that this is being focused only on the housebound and those in nursing homes. What is the rationale for this? Polypharmacy is a problem for anyone on a large number of medicines.</p> <p>‘Vulnerable patients’ (those potentially at increased risk of polypharmacy) has been defined as people living in a care home (either residential or nursing care home). Does this include people with learning difficulty or mental health problems living in a sheltered community?</p> <p>For the purposes of piloting, ‘housebound’ definition is important. Would the definition – “Usually requires domiciliary care from their GP” – help here as many of this group have district nurses calling but attend appointments with their GP or have periods where they have visits and other times when they can come to the surgery?</p> <p>Is the term ‘housebound’ definable? Some patients are intermittently housebound depending on day-to-day variability, and some struggle to go out but are able to do so for more essential reasons – e.g. they would go out to a hospital appointment but not to visit their GP surgery. Does it depend on whether they have access to or can afford transport? Might an alternative description be vulnerable patients who have 3 or more chronic</p>

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	<p>conditions and who are taking more than (5/6/7) medications? The inclusion of polypharmacy to help define vulnerable patients may support the aim of getting GPs to consider polypharmacy as a main part of the review process.</p> <p>Caution is required here in relation to the term 'vulnerable' to describe the group of interest in this domain – vulnerable would normally be considered a broader group than those who are housebound or in care settings so this is confusing. The Clinical Frailty Scale for example identifies the 'vulnerable' as a much wider group.</p> <p>In relation to defining 'housebound', one approach would be someone who is unable to attend the surgery for pro-active care (such as medication reviews and influenza vaccinations), and where this status is not anticipated to change in the next X months (6? 12?). This might exclude those temporarily housebound through illness that are expected to recover.</p>
QOF Indicator 5	<p>There is a risk that being paid to do a medication review becomes a simple matter of ticking a box. It need not require doctors to put any serious thought into the process; still less to be making the difficult and sometimes courageous decisions of stopping some of the drugs. This needs to be addressed within the indicator so that it is more than a tick box exercise.</p> <p>A 'medication review' requires a face-to-face review of medicines and conditions with the person. A face to face would be performed without access to the electronic medical records and clinic letters whilst at the bedside and has the potential of becoming a cursory social visit.</p> <p>There is a risk that under the current workload strain that this extra visiting workload may deter the uptake of this indicator.</p> <p>Polypharmacy is of course a concern in for group, but only one of many potential concerns, and there is a concern that just recording a face to face medication review annually will not be enough to improve patient outcomes. An annual review should be broader, more pro-active and include common unmet needs in this group (including the ones that it is known older people are less likely to present with themselves but cause significant impairments – there is research evidence on this), such as sensory impairment, mood, cognition, incontinence and mobility.</p>
QOF Indicator 6 & 7	<p>There are plenty of patients with such problems who can be dealt with by GPs without referral to other agencies. Once again if adopted it could well result in simply box-ticking, without any serious discussion about the patients' real, personal needs and how to address them.</p>

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	<p>We are concerned about these indicators, as they do not account for tailoring the management according to both severity and patient preference.</p> <p>Whilst there is good evidence of the benefits of psychological therapies in moderate-severe depression and anxiety the evidence for mild disorders is much less clear. GPs do not normally (currently) differentiate by severity in their coding in mental health. The Readcodes used to define the groups would have to be very carefully considered as a result, as some widely used codes such as 'low mood', can be commonly used to indicate transient states as well as more significant problems.</p> <p>Our own work has shown UK GP coding of both anxiety and depression has changed over time with a drift towards using symptom codes. See Rait G, Walters K, Griffin M, Buszewicz M, Petersen I, Nazareth I. Recent trends in the incidence of recorded depression and depressive symptoms in primary care. <i>Br J Psych</i> 2009; 195: 520-524. doi: 10.1192/bjp.bp.108.058636 and Walters K, Rait G, Griffin M, Buszewicz M, Nazareth I. Incidence of anxiety diagnoses and symptoms recorded in primary care. <i>PLoS One</i> 2012, 7(8): e41670. doi:10.1371/journal.pone.0041670</p> <p>We are not suggesting that we go back to recommending the use of the PHQ9 and GAD7 etc. in QOF, however there should be some consideration of severity in the recommendations that relate to treatment.</p> <p>We would therefore suggest that the indicator could be reworded e.g. "that the GP has offered the patient supported self-management with access to the relevant materials or referral to the appropriate psychological therapy service within 3 months of diagnosis, taking into account the severity of the problem and patient preference'.</p>
QOF Indicator 6	<p>This indicator seems to overlap with baseline GMS services?</p> <p>Depression is often recurrent and the distinction between a new episode and relapse is not clear, hence the target group can be ambiguous. Many are recorded as new episodes but in reality it is a relapsing rather than new problem. A three month window is inappropriate as the diagnosis may be gradual rather than a distinct onset, and many patients might prefer to try other self-help approaches initially, only wishing for further help if those do not work sufficiently. Hence the time limit is too restrictive. Our access to psychological therapies may be inadequate which would also make this a negative offer. In my area there is commonly a 12 month wait for psychological therapy and many patients are turned down by the service even when I do refer – not exactly a good offer to a patient with depression. We are concerned that this indicator should be piloted as it stands because the service being flagged up is too variable.</p>

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QOF Indicator 7	GPs' access to psychological treatment is far too poor for this to be a feasible indicator. Many patients with anxiety prefer to try self-help initially and seek help if that is not effective so this time line of three months is too restrictive. Also the spectrum of patients reporting anxiety is very wide – some are acute or reactive problems which do not need referral. It is the persistence of symptoms that requires further action, not the initial diagnosis.
QOF Indicator 8 & 9	<p>The College is encouraged that there is now support for the idea that hypertension is properly considered to be one risk factor of several diseases.</p> <p>Note that indicator 9 includes indicator 8.</p>
QOF Indicator 8	<p>Agreement on the QRISK action level needs to be decided i.e. is it 10% or 20% 10 year risk?</p> <p>Also QRISK is not accurate for people in their 80s and would potentially discriminate against these – we see many chronological 80 year olds who are biologically 70 years old and likely to have another 10 years of quality life ahead of them.</p>
QOF Indicator 10 & 11	<p>Many of the concerns that we have about the use of statins in patients with a QRISK of less than 20% have been well articulated already by Professor David Haslam and colleagues, when the NICE draft guidelines were first proposed [1].</p> <p>The main points of concerns that have already been made are as follows:</p> <ul style="list-style-type: none"> • Lowering the threshold for intervention with statins will lead to the medicalisation of 5 million healthy adults • The wide variation in the reports of adverse effects in statin trials leads one to believe that some trials had “run in” periods when patients not tolerating them were excluded before any analysis took place. In other words the statistical analyses may not truly be “intention to treat”. • Concerns that pharmaceutical companies have not released all the data they have on statin trials. • The effect of publication bias on statin trials, all but one of these was sponsored by pharmaceutical companies. • The fact that most GPs would not ask to be prescribed a statin for themselves, leading to a loss of professional confidence in the healthcare targets they are being asked to meet • Concerns over conflicts of interest of panel members of the NICE guideline panel, who have financial links with pharmaceutical companies

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	<p>In addition to these we would add that the opportunity cost of offering statins to patients with a QRISK of over 10% is massive. The following process would use up time and practice resources that are simply not currently available:</p> <ul style="list-style-type: none"> ➤ Patient attends for blood test/BP check etc. ➤ Explanation of results and risks to patients leading to shared-decision making ➤ Lifestyle advice offered ➤ Statin offered ➤ Measurement of LFTs 1 month after initiation ➤ Explanation of results ➤ Re-measurement of cholesterol: HDL ratio in perhaps 3 months to check efficacy ➤ Explanation of results <p>All of these things take time and resources. Furthermore, it is difficult to quantify the effect on the psychology of the patient.</p> <p>Furthermore, there is no apparent scope available for patients to have a period of time to put lifestyle measurements into place, dietary and weight loss, to see the effect that this might have on their QRISK.</p> <p>A wider discussion needs to be had to decide if an absolute risk reduction of 3-4% is worth the investment of so much time, energy and resources (figures from the Qintervention site). Do patients realise that when they are at a lower risk that statins will prolong their life by 3-4 months over 20 to 25+ years? [2]</p> <p>The group would be happier if this indicator was not used at all, because of all the reasons outlined above. A compromise may be that instead of measuring the percentage of patients with a QRISK of 10% on a statin, that the wording be altered to:</p> <p>“percentage of patients with a QRISK over 10% that have been offered the opportunity to discuss the potential benefits of statins using an approved shared decision making patient decision tool.”</p> <p>Although this wouldn't necessarily mitigate the risks of over medicalisation and massive opportunity costs outlined above.</p> <ol style="list-style-type: none"> 1. http://www.nice.org.uk/Media/Default/News/NICE-statin-letter.pdf [accessed 12 Feb 2014] 2. http://cpr.sagepub.com/content/20/5/827?ijkey=553e60b1aa2b64d2707935ae3908c25568e4b012&keyty pe2=tf_ipsecsha [accessed 12 Feb 2014]

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CVD register of QRISK > 10 Indicator 12	A register of people with QRISK >10 would offer a sensitive measure of the background health of the local community – the only concern is for those who fall outside of the age criteria for QRISK and who would benefit from intervention being denied access to this.
QOF Indicator 10	<p>This indicator does not encourage pursuit of lifestyle modification and in fact promotes over-medicalisation of risk rather than disease. How would a GP demonstrate that a patient is following lifestyle modification before making a decision on statin prescribing? The decision should be made by the patient after a discussion about the pros and cons (and perhaps the controversies around the industry-weighted evidence promoting statin prescribing) and not be swayed by a payment to a GP. This is lifelong prescribing and should not be influenced by a GP's income. Physical fitness is not mentioned – probably counts for at least as much benefit as statin prescribing.</p> <p>Issue of lifestyle modification being ineffective is interesting. It has been already stated how difficult GPs are finding supporting patients to lose weight; the same applies to our efforts to reduce blood cholesterol with dietary modification, and our effectiveness at getting patients to take exercise. If incentivised via QOF, as it is already in an indicator for those with high blood pressure, there is a risk that this becomes a box-ticking exercise with no serious content, as in other areas.</p>
QOF Indicator 11	<p>Same concerns as above – we are concerned about this indicator. It may be better to incentivise the giving of lifestyle advice.</p> <p>As above this one includes indicator 10. What is the rationale for this?</p>
QOF Indicator 12	<p>There is a concern here that this indicator will over-medicalise risk rather than disease, particularly as evidence continues to be hotly debated and is divisive.</p> <p>Those patients who have asked for or accepted treatment will be recalled anyway. Those who know they are at risk can ask for review whenever they want, and those who don't want to be treated will do their best to avoid recall and would probably not want to be on a register.</p>
General	<p>We would suggest a more formal look at the health needs of patients with Learning Disability and Mental Handicap who have problems with obesity, physical activity, poor life-styles and choices. They often are neglected in screening programmes e.g. cervical cytology and their immunisation record can also be problematic.</p> <p>A final comment about future developments on QOF indicators. It is now widely acknowledged that there is a</p>

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	resourcing problem in general practice. Morale is at a low ebb, resources are scarce, we are unable to fill our training posts, which are in turn probably insufficient to replace retiring GPs. This needs to be taken into consideration when developing QOF indicators in the future.

Closing date: Please forward this electronically by 5pm on **23rd February 2015** at the very latest to indicators@nice.org.uk

PLEASE NOTE: The Institute reserves the right to summarise and edit comments received during consultations, or not to publish them at all, where in the reasonable opinion of the Institute, the comments are voluminous, publication would be unlawful or publication would be otherwise inappropriate.