**National Institute for Health and Care Excellence**

**NICE Indicators Consultation**

**Closing date: 5pm – 23rd February 2015**

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| Organisation | **British Medical Association** |
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| **Please note**: comments submitted on draft indicators are published on the NICE website. | |

The personal data submitted on this form will be used by the National Institute for Health and Care Excellence (NICE) for the purpose specified. The information will not be passed to any other third party and will be held in accordance with the Data Protection Act 1998.

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 IND 1 | We would support in principle the use of an overall CVD assessment rather than the current indicators, on the proviso that the components of that risk assessment are determined by the clinician. Some indicators, particularly lipids, are stable over many years and annual repetition might dissuade some patients from attending, as phlebotomy, and to a certain degree measurement of BMI, can be disliked by some patients. We would not support the decrease in age to 25 for annual assessment. It is important that this group receive lifestyle advise and support but the majority of them will have 10 years risks well below the intervention levels and so the quantifying of this on an annual basis will not alter their management, and reduce time available for more important tasks, such as smoking or dietary advise which should be provided independently of any specific cardiovascular risk.  Reducing the time available to 12 months will be counter-productive. These patients have high DNA rates and if one were to miss an annual review late in the qof year there will be no incentive to chase that patient up to ensure prompt review, as the payment will already be lost even if they come after 13 months. It should be noted that many severely schizophrenic patients are under the care of a consultant or are in-patients (some in secure units). Assessing CVD risk may be difficult with this group. |
| QOF IND 2 | We do not support this indicator, as we do not believe the annual recording of BMI will result in a reduction in the BMI of those patients, and would request that evidence be produced that this activity, within a general practice setting, alters outcomes.  The list will select far too many patients for whom obesity is no more a problem than for the general population, particularly young patients with mild asthma or patients with localised osteoarthritis of upper limb joints, such as the thumb (a very common site for OA).  Many patients dislike regular BMI checks and this may dissuade some from attending annual review.  The collecting of this data will impact on other useful activities during review consultations. Even if it only takes 1 minute to do this represents 10% of a normal GP consultation and a larger proportion of the time available within that consultation for clinical work, and so will divert time away from problems that the patient may wish addressed.  The time available for a review should be 15 months not 12. If a patient were to miss an annual review late in the qof year there will be no incentive to chase that patient up to ensure prompt review, as the payment will already be lost even if they come after 13 months. |
| QOF IND 4 | ‘Housebound’ should be defined as ‘The sustained inability as assessed by the GP to get from their place of residence into a motor vehicle despite the provision of suitable walking aids or the use of a wheelchair, and the assistance of one other person’ |
| QOF IND 5 | We would support this in principle however the requirement for the review to be face to face is not beneficial. Some enhanced services are already commissioned for these patients where the model is for a pharmacist to review the medication based on the findings gathered by clinicians previously and experience has shown this to be an effective procedure.  Although it is counter-intuitive, a technical task which can be time-consuming, such as a medication review where many drugs are prescribed, and much monitoring or interactions need to be considered, is often best done without the ‘pressure’ of a patient actually in the room. |
| QOG IND 6 | This cannot be supported.  Many patients with depression are perfectly adequately cared for in general practice without referral. If this were to be introduced the numbers of referrals to psychological services would increase and there is no evidence of current over-capacity in those services. The result will be increasing delays in assessment, reduced quality of care for those who are seen, and an overall reduction in care for this group of patients.  GPs must retain the ability to refer on to other agencies only those patients who will personally benefit, and with an awareness of the impact of the referral on the care that can be offered to other patients in the system.  In order to avoid the more serious adverse effect of this proposal, GPs will probably avoid using the depression code for any patient who they feel should not be referred, and this may have other implications for the planning of mental health services.  This indicator will not measure the stated aim of the last paragraph of the indicator rationale.  Anxiety and depression may coexist but this is not always the case, and so separate indicators are appropriate. |
| QOF IND 7 | This cannot be supported.  Many patients with anxiety are perfectly adequately cared for in general practice without referral. If this were to be introduced the numbers of referrals to psychological services would increase and there is no evidence of current over-capacity in those services. The result will be increasing delays in assessment, reduced quality of care for those who are seen, and an overall reduction in care for this group of patients.  GPs must retain the ability to refer on to other agencies only those patients who will personally benefit, and with an awareness of the impact of the referral on the care that can be offered to other patients in the system.  In order to avoid the more serious adverse effect of this proposal, GPs will probably avoid using an anxiety code for any patient who they feel should not be referred, and this may have other implications for the planning of mental health services.  This indicator will not measure the stated aim of the last paragraph of the indicator rationale.  Anxiety and depression may coexist but this is not always the case, and so separate indicators are appropriate. |
| QOF IND 8 | This indicator can be supported if the requirement for the assessment to be face-to-face is removed. The important feature is that the assessment should be done, and the patient involved in the decision making that results, these two events need not be simultaneous. Many GPs deal with administrative tasks such as reviewing test results in the early morning or late at night when the presence of the patient is impractical.  Prioritisation of those with hypertension or diabetes can be supported. |
| QOF IND 9 | This indicator can be supported if the requirement for the assessment to be face-to-face is removed. The important feature is that the assessment should be done, and the patient involved in the decision making that results, these two events need not be simultaneous. Many GPs deal with administrative tasks such as these in the early morning, or late at night when the presence of the patient is impractical.  Prioritisation of those with hypertension or diabetes can be supported. |
| QOF IND 10 | It is vital for the credibility of QOF that it remains focussed on indicators that make a significant difference to individual patients, where the evidence base for benefit is strong, and the profession as a whole backs their inclusion; the proposal to include a measure of statin use at the 10% risk threshold fails on all these counts. A QOF indicator for this will not measure the quality of care offered by practices to their patients, merely their willingness to resort to pharmacological rather than behavioural intervention, which is hardly a measure of good care.  A practice which involves patients in a discussion about the relative risks and benefits of statin therapy and informs patients with the use of decision aids to show ‘numbers needed to treat’ and ‘numbers needed to harm’ will have lower prescribing figures for statins than one which simply prescribes, but will be providing higher quality care, so this proposed indicator is incompetent.  Effective primary prevention of cardiovascular disease is a difficult and complex clinical situation, with a plethora of factors to take into account, the most important of which are the views of the patient. Attempts to evaluate this nuanced discussion by measuring crude prescription numbers is not only medically unjustifiable but incentivises an interventionist doctor-knows-best model of care which disempowers patients and undermines informed patient choice.  The age range is too great to be used as a quality measure, as all patients in the upper age range will have 10 year risks greater than 10% by virtue of age alone, but many of these will be unsuitable for statin therapy due to comorbidities, intolerance, or limited life expectancy. The large number of patients requiring completely appropriate exemption reporting will negate the statistical validity of the collected figures.  With regard to the two specific questions, lifestyle modification will not have a significant impact on risk as measured by the QRISK2 calculator on early review. Annual formulaic intervention on smoking, alcohol, and diet for all patients is an unproductive activity and negates the sensible modification of hypertension indictors introduced in 2014-15.  If it is desired to put forward an indicator regarding statins into the negotiation process for inclusion into QOF we would recommend an indicator measuring the patients who have had at diagnosis a discussion about statin therapy using a recognised decision making aid. |
| QOF IND 11 | It is vital for the credibility of QOF that it remains focussed on indicators that make a significant difference to individual patients, where the evidence base for benefit is strong, and the profession as a whole backs their inclusion; the proposal to include a measure of statin use at the 10% risk threshold fails on all these counts. A QOF indicator for this will not measure the quality of care offered by practices to their patients, merely their willingness to resort to pharmacological rather than behavioural intervention, which is hardly a measure of good care.  A practice which involves patients in a discussion about the relative risks and benefits of statin therapy and informs patients with the use of decision aids to show ‘numbers needed to treat’ and ‘numbers needed to harm’ will have lower prescribing figures for statins than one which simply prescribes, but will be providing higher quality care, so this proposed indicator is incompetent.  Effective primary prevention of cardiovascular disease is a difficult and complex clinical situation, with a plethora of factors to take into account, the most important of which are the views of the patient. Attempts to evaluate this nuanced discussion by measuring crude prescription numbers is not only medically unjustifiable but incentivises an interventionist doctor-knows-best model of care which disempowers patients and undermines informed patient choice.  The age range is too great to be used as a quality measure, as all patients in the upper age range will have 10 year risks greater than 10% by virtue of age alone, but many of these will be unsuitable for statin therapy due to comorbidities, intolerance, or limited life expectancy. The large number of patients requiring completely appropriate exemption reporting will negate the statistical validity of the collected figures.  With regard to the two specific questions, lifestyle modification will not have a significant impact on risk as measured by the QRISK2 calculator on early review. Annual formulaic intervention on smoking, alcohol, and diet for all patients is an unproductive activity and negates the sensible modification of hypertension indictors introduced in 2014-15.  If it is desired to put forward an indicator regarding statins into the negotiation process for inclusion into QOF we would recommend an indicator measuring the patients who have had at diagnosis a discussion about statin therapy using a recognised decision making aid. |
| QOF IND 12 | This register will include far more patients than is practical to prioritise, particularly with no limit on age range, and will identify people who have a lower than average cardiovascular risk for their age. If a register is to be produced it should more adequately target those with most to gain by intervention, and this could be done by substantially reducing the upper limit and/or increasing the risk threshold for intervention. |
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**Closing date:** Please forward this electronically by 5pm on **23rd February 2015** at the very latest to [indicators@nice.org.uk](mailto: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.