

## NHS Scotland GMS Implementation

### PRIMARY CARE QUALITY EVALUATION GROUP

Note of the meeting on Wednesday 21 March 2007, 10.30am – 1pm in Springfield House, Stirling.

**Present:** Dr Nadine Harrison (Chair), Richard Dobbie, Catriona Hayes, Julie Kidd, Dr Philip McMenemy, Dr John Steyn, David Whipps, Nic Zappia

**In attendance:** Lee Henderson (*notes*)

**Apologies:** Martin Moffat, Robert Stewart, Steven Wilson

#### 1. Introductions, Apologies and Welcome

NH welcomed those present and introductions were made for the benefit of LH.

#### 2. Minutes of the Meeting of 17 January 2007

The minute of the meeting of 17 January 2007 was agreed as an accurate record.

#### 3. Matters Arising

Item 3, last bullet point: The CHP exercise undertaken by ISD was a scoping exercise and not an established group and therefore there is no overlap of data collection.

#### 4. Information Gathering

##### 4.1 Stocktake of NHS Board analytic work

A letter was sent out to all Boards on 9 February 2007, via GMS leads, requesting information on analytic work undertaken. A second request has since been sent out, with 5 NHS Board areas replying: Borders, Greater Glasgow & Clyde, Lothian, Tayside and Shetland. With the exception of NHS Glasgow and Lothian, there is little current work being undertaken, mainly due to lack of resource. NHS Tayside had however commissioned Matt Sutton to analyse 2004/5 data and were involved with Lothian in piloting the practice analyser software. The poor response level was noted emphasising the need for a definite contact in each Board.

##### **Action ALL**

ISD are building QOF data into their data warehouses and are looking into providing functionality equivalent to that provided by Dundee University's QOF Practice Analyser tool. In the medium to long term there is scope for ISD to produce a front end system for Boards to use in order to analyse their practice QOF data.

This tool is currently used as part of the 'QOF Plus' programme pilot in East Lothian CHP. It was not clear whether this tool could be used at a Board level to aggregate data. It was noted that the tool can only be used on a voluntary basis as it has not been agreed by SGPC for QOF reviews. It was noted that NHS QIS have bought the rights to the tool and are developing a web based version.

##### 4.2 Research Work

Members did not believe they had the experience or connections to undertake overviews of research work effectively. Kate O'Donnell of Glasgow University will be invited to join the group to fulfil this gap.

The remit of this position would be to provide updates on literature searches, relevant ongoing work, published and non published papers and to act as a liaison with researchers in the field.

##### **Action NH**

#### 5. Approach to Analysis

5.1 PMcN provided a presentation on the methodology for evaluation used in Lanarkshire for DM6/20 (appendix 1).

CH had done some further work with these data looking at coverage and adjusting some of the daily dose information.

The difficulties in interpretation were highlighted and that it was important to ensure that how the data was presented did not lead to conclusions which were not valid.

5.2 CH provided a presentation on the effects of exception reporting in Epilepsy4 and DM6 (appendix 2).

It was highlighted that the level of exception reporting in Epilepsy4 may be due to patients receiving specialist care and by patients misinforming GPs of seizures to qualify for DLA/incapacity benefit reviews.

It was noted that with DM6, when exception coding was removed, there were no correlation between achievement and deprivation

5.3 The remit of the group is to look at clinical outcomes and their impact on other services. It was agreed that the group would not look at costs although outcomes from the analyses would have implications for this. The aim is to ensure that explanations for outliers are identified and that practices are encouraged to move towards a good clinical approach, consistent across practices.

5.4 With regards to practice staffing, although work has been undertaken to establish WTE in general practice, SGPC has not agreed to Boards requesting this information on a mandatory basis and therefore the voluntary return of data does not give a clear picture of the workforce. It is hoped that this would be addressed in subsequent years so that achievement could be related to staffing levels.

5.5 It was suggested that practice deprivation does not always give a true reflection as patients registered with a practice may live outwith the practice postcode. However, the two commonly used measures of deprivation (SAF and SIMD) both use patient postcode rather than practice so this is not a problem. The SAF is in itself not a deprivation measure but it does use the Arbuthnott Index within it. It is used in global sum calculations whereas SIMD is increasingly used by CHPs, Boards and researchers. A decision would be needed on the most relevant deprivation scale to use. **Action JK, RD, ALL**

5.6 The QMAS extract does not allow for breakdown of reasons for exception reporting. It was agreed that, given the information is readily available, Lothian would pilot a Board exercise to report the distribution of reasons for exceptions and in particular what proportion were DNAs for indicators for which they already had data. **Action JS**

5.7 SPICE data might also contribute to this information. JK would follow this up. **Action JK**

5.8 NH suggested the following terminology to avoid confusion:  
**payment achievement** – exception reported patients not in denominator  
**coverage** – exception reported patients put back into the denominator (including new registrations)

It was also agreed to **use ISD data** (not QMAS data) for our analyses unless there were specific local analyses e.g. for 5.6.

## 6. Future Work – Action Plan

6.1 It was agreed that we should focus on data analysis which answers important questions. The aim included modelling of outcomes such as disease prevented/ life years saved.

6.2 With this in mind, indicators for closer analysis would be selected initially on the basis of (in no particular order)

- Variability of payment achievement and/or coverage
- Significance of outcome
- Low coverage
- Correlation with deprivation
- “quality”- linked to Matt Sutton’s key indicators

- likely impact on other services/ prescribing etc
- dominance of DNA in exception reporting reasons (from Lothian work)

These all lent themselves to a reason for looking at the data.

All would look at the list tabled by CH in the first instance and return comments on these to CH/NH, plus additional suggestions based on these criteria. **Action ALL**

From this list, further selection would be made based on high level analysis of data, leaving a short list for full analysis.

6.3 2005/6 data would be used to test out useful analyses which might be used by Boards for 2006/7 data following publication in September.

6.4 Pitfalls in analysis might be noted as they came to light (ie common errors and assumptions which were not statistically valid) so that Boards were alerted to them.

## SUMMARY OF ACTION POINTS

Task	Action	Actioned by
Select certain indicators based on criteria in 6.2.	Review the list of indicators circulated by CH (appendix 3) and comment to NH/CH on their appropriateness, and of any additional indicators that should be considered. .	ALL
	Produce a revised list of indicators based on these returns and conduct initial analysis	NH/CH
Look at reasons for exception coding.	Look at the distribution of reasons for exception coding for 2005/06 data available in Lothian. In particular what proportion are DNAs as this may be a reason to address inequalities. Examine work done by SPICE	JS JK
Scope the development of a tool/ guidance for Boards to use to effectively analysis specific indicators.	Develop using the outcomes from above. Members are also asked to email NH anything that does not work or is unhelpful so data is not misinterpreted	CH/JK/NH initially then ALL NH ALL
Identify a named person in each Board for contact	Members to email NH with suggested names for their own Board and those not responding to stocktake (see 4.1)	ALL

## 7. Date of Next Meeting

Proposed dates for mid to late May will be distributed by email