

NHS Scotland GMS Implementation

PRIMARY CARE QUALITY EVALUATION GROUP

Note of the meeting held on Thursday 14 June 2007, 10.30 am – 1 pm, NSS, Gyle Square

Present:

Nadine Harrison (Chair) (NH), Richard Dobbie (RD), Catriona Hayes (CH), Julie Kidd (JK), Martin Moffat (MM), Phillip McMenemy (PM), Kate O'Donnell (KO), John Steyn (JS), David Whipps (DW), Steven Wilson (SW), Nic Zappia (NZ)

In attendance:

Lee Henderson, GMS / PC Programme Support Team (*notes*) (LH)

1. Welcome, Introductions and Apologies

NH welcomed those present and introductions were made for the benefit of KO and members noted that Robert Stewart will not join the group as he has moved to NHS 24.

2. Minute of the meeting of 21 March 2007

The minute of the meeting of 21 March 2007 was agreed as an accurate record.

3. QOF Research Information

It was agreed that KO would bring together an initial summary of published research on QOF/quality related issues across the UK and provide an update for each meeting. She would give a brief critical appraisal of the research and comment on its relevance to the group's work. Where a paper seems particularly relevant to the work undertaken by the group, KO will make a brief presentation to the group.

4. Discussion of Group Objectives and Work Plan Development

NH suggested that the group needed to focus more on its key objective which was to assess positively the effects of the QOF to fulfil a strategic return on the investment. This included both effects on health outcomes but also the impact on other services and treatments, e.g. prescribing, diagnostic services, labs and hospital services/ admissions.

It was agreed that the group would adopt a high level approach to covering key disease areas, linking with prescribing trends, emergency admissions and lab information and then filter down to single indicators that logically cover the disease area. Clinical commentary would be applied to analysis.

It would be helpful to have a regular report on the trends in key prescribing data for each quarter. Similar trend data for emergency admissions may not be so useful but it was agreed that this should be looked at again to see if certain conditions (e.g. asthma) could be monitored. Lab data was not recorded centrally but it may be possible to obtain an update on previous data.

Actions agreed were:

- Prescribing data
- Emergency admission data
- Lab information may be available from Dr Bernie Croal

Action JK/RD
Action JK/RD
Action NH

Action NH / JK / KO

It was agreed that the 'audience' for the work of the group is Boards and the Scottish Executive. However care must be taken that the information produced by the group is not misinterpreted.

It was agreed that a plan of what the group will do could be drafted and shared with members of the group for comment.

Action NH / CH/ MM

5. Diabetes and CHD / Stroke Reports

It was agreed that the reports produced by CH were a useful approach and that in addition a breakdown at Board level would be beneficial. A certain amount of analysis, generic to all Boards, can be factored into ISD workplans to follow on immediately from web publication. Routine data will be established as a starting point and trend analysis can be undertaken where possible. A publications template will be established for agreement by the group (see also item 10 below).

Action JK / RD

6. Selection of Indicators

The selected indicators detailed in the document 'Initial Analysis of Selected QOF Indicators for Quality Evaluation Group' were chosen because of their high variability in terms of coverage. It was agreed that this aspect of work should continue as it will be helpful to practices in highlighting useful indicators and pitfalls of analysis as well as informing work around CVD. It will also determine whether it is feasible to bring together certain data.

Given concerns around CHD10 and Epilepsy 4, it was agreed that they would remain in the documents with a commentary on why interpretation is not as expected.

Action CH/ All

7. Reasons for Exception Reporting

JS provided an overview of work ongoing in Lothian around exception reporting. The exercise focuses on the top 10 practices, asking them to explain why there was a high level of exception reporting. Some practices will receive a visit to establish if there are inconsistencies in approach.

Unfortunately, this work does not give an overview of the distribution of reasons for exception reporting across indicators as specific indicators are selected for each practice.

The exercise has however highlighted that many practices are mistakenly blanket exception reporting for whole indicator sets instead of specific indicators.

Exception reporting is valid for a 15 month period however many practices are unaware that the criterion for exception reporting also need to have been met during this 15 month period. Practices need to check exception reporting recorded in the previous year is still valid during the current financial year. There may be a need for this to be clarified to practices. JS will email NH who will take this issue forward.

Action JS / NH

SPICE have done some work around the Stroke/TIA indicators. Publication of this work is pending.

Action KO

8. Potential for Analysis of QOF Impact on Other Services

Further to the general discussion under item 4, it was agreed to look in detail at the CVD package (including diabetes) in the first instance then COPD.

Links could be made with the work already done by Gary McLean in Glasgow on stratification of practices for deprivation, practice list size, demography, rural and remote, training practice etc and ISD data on prevalence, achievement, and exception reporting. The Platform Project

work produced by Matt Sutton would also be useful in this context. ISD, and CH's work on variability, with the aim to highlight outcome indicators.

It was agreed that an initial check would be made for trends in

- amputations (for improvement in diabetes care)
- CABG and angioplasty (for CHD)

It was noted that SCI DC data is not real time especially for non- GPASS practices and therefore not as reliable as data held on primary care systems.

Action: JK/ RD

9. Pitfalls of Analysis and Recommendations for Boards

It was agreed that this aspect is not a separate entity of the group remit but will be informed by the agreed process detailed in item 4.

10. Structure of ISD published tables / other reports

JK noted that now was a good time to discuss any potential changes to the contents of the ISD QOF pages, in advance of the major publication of 06/07 data at the end of September. For example, additional tables or table elements could be included (e.g. median achievement at Board level requested by JS), and further commentary to emphasise particular issues (e.g. emphasising that it is not possible for all practices to achieve 100% of points).

As part of ISD QOF workload planning, JK noted that she could consider producing "generic" reports for Boards as soon as possible after publication, for example to provide a standard set of output on coverage in the clinical indicators. This would fit in with aspirations under item 5 and might reduce the workload for ISD associated with ad hoc data requests.

Action JK/RD

11. Date of Next Meeting

Dates will be distributed for:

- late August - to discuss the publication template
- September/October - Full group meeting