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QOF vs NICE

As a FHO2 (Foundation Year 2 House Officer) in general practice, I recently performed an audit on smoking cessation practice at my surgery. Naturally I turned to 'Gold Standard' national guidelines to set my audit criteria. However, I was rather disturbed by the discrepancies between the 2006 QOF criteria[1] for monitoring smoking status and management of smokers and the 2006 NICE Public Health Guidance on smoking cessation.[2]

The NICE guidance is the first public health guidance issued on smoking cessation with the emphasis being on prevention of smoking-related complications. The guidelines advocate the use of 'Brief Interventions' (simple opportunistic advice to stop which can be performed by clinicians across the board) and early referral to smoking cessation services.

Using QOF targets we are currently identifying: 1) smokers, 2) smokers with chronic disease, 3) smokers with chronic disease who get advice/referral. We do not routinely know: 1) the smoking status of all those on GP lists every 15 months, 2) if the smoking status of non-smokers has changed, 3) if smokers without chronic disease are getting advice/being referred/being offered pharmacotherapy. As part of the 2006 guidelines, NICE publish recommended audit criteria which are poorly comparable to the QOF targets but which tackle these shortfalls mentioned. I find this particularly surprising considering that the NICE guidance preceded the publication of the GMS contract.

In the current environment where smoking-related disease, and more specifically, cardiovascular disease, is the number one burden to the NHS, I agree that we need to embrace a more comprehensive set of guidelines for the management of smoking. In order to achieve this goal, however, there needs to be some clarity and stream-lining of guidance between primary care and major clinical governing bodies. I would like to see accelerated efforts to establish this relationship and encourage a response to this letter from both parties.

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Computer records

In Scotland, the first step towards a centralised medical database has already occurred. Described as the Emergency Care Summary (ECS), patient consent has been obtained by a single mailing to each household. Using this as an assumption of informed consent, data has been extracted from general practice clinical systems.

We had misgivings about this consent process being adequate. Considering all the options, including the possibility of an 'opt-in' mandate, we decided to mail patients individually to offer an opt-out of this information sharing.

We have so far received 287 opt-out requests for a list size of 1710. For Scotland, there have been a total of 620 opt-outs for a population already included of 5 million. Our figure of 16.5% compares to a national average of 0.01%; a factor 1330 times greater.

Our results question whether the governments' strategies of obtaining consent for the release of such information reflect proper process. Many patients refused because they were unaware that consent to allow data migration had been obtained.

There is still time to evaluate the usage of the ECS to see how often it has been used and to define the benefits of better clinical outcomes. In the final analysis, before we can obtain informed consent for these new and relatively untrialled programs, we need to understand the benefits for individual patients clinical outcome as well as being clear about the extent of any potential for inappropriate or malicious use of information.

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Developing primary care treatment of depression

Tylee and Walters[1] make a good case for the development of a chronic disease model for the management of depression in primary care. Some of the figures that they quote deserve further comment. It is of concern that between 30 and 50% of patients treated for depression with anti-depressants in primary care do not show a response, while only 30% achieve remission. It is also of concern that only 10% of patients on antidepressants complete an adequate course. Finally, it is of concern that 76% of patients with residual symptoms relapse and that 12 months after diagnosis, 45% of patients with severe symptoms remain depressed, and 40% of patients have a relapsing remitting course over a decade. These facts clearly lead up to the statement that 40% of patients with depression are eligible for 'step 4' secondary care interventions.

It is interesting to see how these statements appear to be born out in practice. We work in a community mental health team with a catchment population of 60 000. Out of these, in 10 months 456 patients were seen in the clinic. Of these, 63 had a diagnosis of recurrent depressive disorder, 12 had psychotic depression, 28 had anxiety and depression, 73 were seen for depressive episodes, and 41 had bipolar affective disorder. Although it is clear that depressive illness makes up the bulk of the morbidity which we treat, there is clearly concern that these figures are unlikely to be equivalent to the 40% of depressed patients of our population who are eligible for secondary care services according to the figures quoted by Tylee, hence Tylee is right that many patients who are in fact eligible for treatment in secondary care are in fact treated in primary care.