University of Birmingham and University of York Health Economics Consortium (NCCID)

Development feedback report on piloted indicators

QOF indicator area: Serious mental illness

Pilot period: 1st October 2014 – 31st March 2015

Potential output: Recommendations for NICE menu

Contents

Summary of recommendations

Indicator

1. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses aged 25 to 84 years who have had a CVD risk assessment performed in the preceding 12 months.

Acceptability recommendation:

- Band 2: 60-69% of practices support inclusion

Implementation recommendation:

- Band 3

Band 3: major problems identified during piloting or anticipated in wider implementation. Possibly resolvable through the actions described in band 2 but indicator requires further development work and/or piloting.

Cost effectiveness recommendation:

- Highly cost effective at a base case of 6 points.

Issues to consider:

Issue	Detail	Mitigating activity
Hitting the target but missing the point	Practices are able to run QRISK2 calculation using data held on the clinical system or, where this is missing, substituting population averages.	Guidance could stipulate the circumstances under which pre-held data could be used and when this should be updated but this will be difficult to monitor.
Will this distract from lifestyle optimisation?	Some practices expressed concern that colleagues might focus upon the risk score and opportunities for lifestyle advice would be missed.	This indicator could be used in conjunction with other indicators which focus upon discrete CVD risk factors such a smoking and BMI.
This indicator does not address metabolic risk	A small number of practices noted that this indicator did not address the increased risk of diabetes for people in this group.	Indicators exist on the NICE menu for the monitoring of blood glucose in this group of patients but are not currently incentivised.
How frequently should the risk estimate be recalculated	Practices differed in their views as to whether an annual recalculation was necessary, especially in younger patients. An annual recalculation was selected for piloting to remain consistent with the recommendation1.5.3.2 in CG178 and recommendation 1.6.2.39 in CG38.	

Overlap with the NHS Health Check in England	The NHS Health Check targets people aged 40-74 for CVD risk assessment and lifestyle review.	

Background

As part of the NICE-managed Quality and Outcomes Framework (QOF) process, all clinical and health improvement indicators are piloted, using an agreed methodology, in a representative sample of GP practices across England, Scotland Wales and Northern Ireland.

The aim of piloting is to test whether indicators work in practice, have any unintended consequences and are fit for purpose.

Practice recruitment

Number of practices recruited:	36
Number of practices dropping out:	1
Number of practices unable to interview:	3
Number of practices interviewed:	32

[31 GPs, 7 practice nurses, 14 practice managers, 1 health care assistant and 2 administrative staff = 55 primary care staff most involved in QOF piloting]

All percentages reported have been calculated using the 36 practices recruited to the pilot as the denominator.

Piloted indicators

1. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses aged 25 to 84 years who have had a CVD risk assessment performed in the preceding 12 months.

Assessment of clarity, reliability, feasibility, and acceptability

Clarity

No concerns noted during piloting or the GP focus group, although it was noted that clarity could be improved by stating the risk assessment tool to be used in the indicator wording.

Reliability and feasibility

We were able to develop business rules to support this indicator.

Issues to be resolved prior to implementation:

Issue	Detail	Mitigating activity
Is QRISK2 the only tool to be included?	In the pilot only QRISK2 read codes were counted as a success. In the last 5 years we have had QRISK only, multiple options and now QRISK2 only.	Review with NICE and clinical coding experts and SDS team. Will need to be consistent with other indicators which incentivise CVD risk assessment.
Need to check that the code clusters are still valid	There have been code releases since the pilot. For example there are now CKD resolved codes	Need to carry out impact assessment.
CKD clusters out of sync with live QOF	QOF has had to update the CKD clusters to take into account new classifications.	Check and update CKD clusters.
Are patients in remission/ recovery to be included.	The pilot did not exclude patients in remission/ recovery from SMI	Need to discuss with evaluation team and possibly NICE
Do the rules need to check that for pre-existing diseases that a QRISK2 check has been coded	For the pilot happy for those with the listed conditions to be excluded and no need for the Business Rules to also check if these patients have had a QRISK2 done as part of their processes	Clarification from evaluation.

Acceptability

Practices were generally supportive of the intent behind this indicator and acknowledged the increased risk of cardiovascular disease for patients diagnosed with a serious mental illness.

Twenty-five practices (69.4%) thought that this indicator should be considered for inclusion in QOF with a further 2 practices (5.6%) being ambivalent. Five practices (13.9%) did not think that this indicator should be considered for inclusion in QOF.

'…we were already incorporating obviously, a lot of their physical health problems erm, in that review, so it was something that we were used to doing for QOF and the only real additional thing was, was the QRISK, which is straightforward and easy to do and work out…' (GP, Practice ID25)

'I, I think QRISK is better, because it gives you the overall risk assessment. But you need to collect the other factors to get the QRISK, anyway [yeah].' (GP, Practice ID008)

'No, erm, I, I mean, I, I agree with the, the, erm, sentiment, if, if you like,… but, you know, again, it might be that that indicator is, it's an indicator for an indicator sake. If you don't do, if you just tick the box, it doesn't mean anything.' (GP, Practice ID007)

Practices varied in their approach to implementing this indicator. Most practices added elements of the QRISK2 to their annual review templates. Where practices did this a small number commented on the difficulties of getting patients to attend for annual blood tests. Difficulties were also noted in relation to coordinating the tests and their results in a timely manner in order to make the QRISK2 calculation using recent patient values during the review appointment. Some practices questioned the value of repeating blood tests on an annual basis, especially in younger patients, where lipid levels in particular might remain stable. A small number of practices made the QRISK2 calculation using patient data already held in the medical record. They then called in those patients with a risk of greater than either 10% or 20% to discuss their risk and treatment options. A small number of patients were commenced on statins.

The practices who did not think this should be considered for inclusion in QOF or who were ambivalent expressed concerns about the proposed age range, proposed frequency of testing and overlap with the NHS Health Check programme. They also expressed concern that the use of a risk estimation tool may provide a false reassurance if the result was low and distract GPs from focusing upon lifestyle issues such as weight, smoking and alcohol consumption. One GP commented:

'Lifestyle optimisation is critical' (GP, Practice ID021)

'… that's what worries me, because what worries me is that – you see, if you're going to remove the individual ones and just do this, then I think that would be highly inappropriate…. No, because the truth is, erm, I think, for example, you don't have to do the BMI each year to do that, but I think – and I also I think, you know, these people have a massively high risk of diabetes and I think that should be thought of separately. So I think that should be a separate indicator and I think it should also remain a separate indicator. So if I was really do this, I think this should be a new indicator, not a replacement.' (GP, Practice ID016)

'...and a lot of times, rather than actually looking at [mmm] the, the values erm, it actually acts as an incentive for people to improve [mmm], so if you're having a discussion around their BMI every year [yeah] or around their cholesterol, you know, they go with a target and some of them engage [mmm] with that quite well but if you're not checking the whole thing for five years, then [mmm]... so I think, in, in that sense perhaps, standalone indicators are better [yeah] erm... yeah.' (GP, Practice ID001)

'If you do the QRISK then you're thinking more down the lines of statins, 'cos that's how, yeah, and if you do the other things then you're thinking more in terms of type two diabetes. Erm, maybe you should be thinking about exercise and healthy diet. Erm, but we probably bias it more towards putting people on more pills.' (GP, Practice ID002)

Other practices felt that this would not be the case and that they would continue to address lifestyle issues as they were identified.

*'[*calculating QRISK2 was*] A more complete way of assessing their risk ….A holistic approach.' (GP, Practice ID029)*

Concerns about the proposed age range and frequency of testing were expressed by some practices. Two practices (5.6%) expressed the view that this indicator should be restricted to patients aged 40 years or over. Other practices questioned the value of performing a risk estimate in younger patients.

The question of how often the risk estimate should be recalculated was raised with practices. Of the twenty-seven who expressed a view, twelve practices thought that repeating annually seemed reasonable. The remainder suggested time frames of 3-5 years, that frequency of calculation should be determined by the level of risk identified or be based upon the patient's age.

'I don't think there is a lot of additional benefit by recalling and doing the scoring every year. I wonder if once in five years would be appropriate erm, but if other, other indicators are taken out, for example, they're not getting their annual checkups done otherwise then erm...' (GP, Practice ID001)

'Yeah, this was a difficult one. I mean we did talk about – there's such a variation in age group – Serious Mental Health group. You know, if you've someone who is – she is 25, her QRISK is not that likely to change significantly in a 12 month period, whereas obviously that – that's quite different for someone who's a bit older erm, and on some of the, the QOF er, guidelines by having gone to three yearly. We thought that that might be erm, adequate for a lot of the, the patients that we have on our register.' (GP, Practice ID025)

Practices had mixed views as to whether this indicator would promote parity of esteem and help to improve physical health in people with an SMI. Fourteen practices (38.9%) thought that this indicator had the potential to improve physical health as these people are at increased cardiovascular risk. Eight practices (22.2%) did not think it would improve physical health, citing reasons such as the need for a more holistic approach to care and that often what was needed was for patients to make lifestyle changes and that this indicator would not promote this.

'Obviously it's got the potential to reduce the risk of deterioration of health. I don't think it's going to improve the health today, but I think it will reduce the risk of getting cardiovascular disease tomorrow, which we know there's a massively high risk of. So I think it's eminently appropriate.' (GP, Practice ID016)

'… screening them is great, because the evidence is pointing to there being a, a link, and that's really important. It will potentially make the patients feel they are having something worthwhile, they are getting engaged with their practice. We have more contact with them. We get to see what they're like in a different realm of not being under their mental illness umbrella.' (GP, Practice ID004)

'Their smoking by far and away the biggest risk factor and I don't know that this addresses, getting them to you stop this difficult group.' (GP, Practice ID013)

'No. It will be another tick box exercise … I don't think it will change very much at all. Because to do that you need to change their behaviour.' (GP, Practice ID005)

Assessment of implementation

Assessment of piloting achievement

	Final 1 (QRISK2ASS L6M)		Final 2 (QRISK2ASS L12M)	
MHP901 INDICATOR	Baseline	Final	Baseline	Final
Number of Practices Uploading	**27**	**26**	**27**	**26**
Practice Population	204,852	198,058	204,852	198,058
Mental Health Register	1,406	1,388	1,406	1,388
Excluded regardless				
Rule 1 True (patient age)	91	88	90	88
Excluded if they do not meet Numerator criteria				
Rule 3 True (qrisk exception)	0	0	0	0
Rule 4 True (recent registration)	39	22	39	21
Rule 5 True (mental health exception)	142	178	142	174
Rule 6 True (recent diagnosis)	15	8	15	8
Total Exclusions	287	296	287	291
MHP901 Denominator	1,119	1,092	1,119	1,097
MHP901 Numerator	139	331	139	396
Numerator as % of Denominator	**12.42%**	**30.31%**	**12.42%**	**36.10%**

Practice achievement rose by 17.89% during the 6 months of the pilot (Final 1 in table above) and by 23.68% when calculated over a 12 month period (Final 2 in table above). At a practice level, final achievement (measured over 12 months) ranged from 0% to 100% (median = 22.48%, Inter Quartile Range 9.58%: 53.27%).

Changes in practice organisation

Reported changes to practice organisation were minimal with most practices adding the information necessary to make the QRISK2 calculation to their annual review template. Some changes to practice organisation might be seen on widespread implementation if practices opt to calculate the QRISK2 estimate outwith of a consultation and only call in those patients whose risk is above a certain threshold. Also some practices reported using their HealthCare Assistant staff to call patients in prior to their annual review to take bloods for lipids etc. A small number of practices reported difficulties in coordinating this.

Resource utilisation and costs

Taking blood annually for a full lipid profile will have an associated cost in terms of laboratory testing and phlebotomy.

Barriers to implementation

None identified.

Assessment of exception reporting

Exception reporting rates are not insignificant at 15.6%, although this is broadly comparable with other indicators aimed at this population. The greatest contributors to this are the generic mental health exception codes of 'patient unsuitable' or 'informed dissent'. During piloting we did not automatically exclude from the denominator patients with a previous risk score of >10% or those already being treated with a statin. Incorporating these rules into the extraction may result in a reduction in patients exception reported as being unsuitable for the indicator. Many practices commented that this can be a difficult group to engage with their healthcare and who frequently do not attend appointments, although this was not universal.

Assessment of potential unintended consequences

The most significant unintended consequence of this indicator is that it will distract practices from the optimisation of lifestyle factors which may be present despite a low estimated 10 year CVD risk. This risk is increased should practices elect to make the QRISK2 calculation using previously collected patient data and/ or population estimates. QOF Guidance could state that only patient level values should be used in the calculation but this will be difficult for CCGs and Local Area Teams to monitor.

The Committee may wish to consider making recommendations that this indicator is used alongside indicators which focus upon discrete cardiovascular risk factors. This could also address some of the concerns raised by stakeholders about the inclusion of a lower age range in the indicator wording. As discussed earlier this is necessary as QRISK2 has not been validated in those younger than 25 years old.

Assessment of overlap with and/or impact on existing QOF indicators

None identified.

Suggested amendments to indicator wording

We would recommend the following amendments to the indicator wording to bring it in line with existing indicators:

The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses aged 25 to 84 years (excluding those with pre-existing CHD, diabetes, stroke and/or TIA, those with a previous risk score of >10% or those currently prescribed a statin) who have had a CVD risk assessment performed in the preceding 12 months (using an assessment tool agreed with NHS CB).

Appendix A: Practice recruitment

We planned to recruit 34 practices in England and 2 in each of the Devolved Administrations. English practices were to be representative in terms of practice list size, deprivation and clinical QOF score. Given the limited variability in clinical QOF score we excluded practices with a score of ≤ 10th centile. Practice list size and IMD scores were divided into tertiles and a 3x3 matrix created with target recruitment numbers for each cell. These are detailed in the table below.

	List size		
IMD Score	Low	Medium	High
Low	3	4	5
Medium	3	4	4
High	4	4	3

As previously presented to the Committee, practice recruitment has been extremely challenging. At the beginning of this pilot we had recruited 31 practices in England and 5 in the Devolved Administrations (2 in Wales, 2 in Northern Ireland, 1 in Scotland). Practice recruitment by strata is shown in the table below with cells in bold where we failed to meet target numbers. We also over recruited in two stratas which is shown by the numbers in the table.

	List size		
IMD Score	Low	Medium	High
Low	**2/3**	**3/4**	**2/5**
Medium	4/3	4/4	**3/4**
High	6/4	4/4	3/3

Appendix B: Indicator development detail

At the June 2014 Advisory Committee meeting the Committee discussed the potential for new indicators relating to the care of people with serious mental illness which may contribute to their physical health and promote parity of esteem. Two potential indicators were developed as detailed in the table below.

Recommendation	Potential indicator	Issues/ Questions
Increasing the parity of esteem between mental and physical health: CVD risk assessment Reintroduction of physical health checks for people with an SMI as per CG178 (Psychosis and Schizophrenia in adults) and CG38 (Bipolar disorder)	The percentage of patients with schizophrenia, bipolar affective disorder or other psychoses who have had a CVD risk assessment performed in the preceding (tbc) months. The percentage of patients with schizophrenia, bipolar affective disorder or other psychoses who have had the following care processes performed in the preceding 12 months: • BMI measurement • Blood pressure measurement • Glucose levels (if over 40 years) • Lipid levels (if over 40 years) • Record of alcohol consumption • Record of smoking status	Are there any barriers to implementing this indicator? Could these care processes be bundled together in a single indicator? What are the barriers to implementing these care processes? Singly? As a bundle?

GP focus group

A focus group to discuss potential indicators was held on 23rd July 2014 where all potential indicators were discussed. Focus group attendees were volunteers recruited via our database of GPs who had responded to previous invitations. From the volunteers we purposively selected 15 GPs to attend the focus group to ensure an equal balance of men and women, representation from minority ethnic groups and a range of ages.

All of those invited attended the meeting. Two-thirds were male. Approximately half the participants described themselves as being of white ethnicity (n=7). Participants were reimbursed £250 for their attendance.

Gavin Flatt and Dr Shirley Crawshaw attended on behalf of NICE.

There was general agreement that this group of patients were at greater risk of cardiovascular disease but there was some concern as to whether a focus upon assessment was the right thing to do. Participants noted that this group are not seen that frequently and that therefore it might be more important to monitor their mental rather than physical health. One participant expressed concern that inviting patients to have these checks performed annually might be perceived as 'hounding' and be detrimental to the doctor-patient relationship. However, given their increased risk of cardiovascular disease, CVD risk assessment seemed a reasonable thing to do, although the limited evidence that this prevented future heart attacks was also noted.

Participants were not supportive of the bundled physical health care process indicator being progressed to piloting. It was noted that these processes do not lend themselves to being completed at the same time which makes a bundle challenging to implement. Additionally not all the processes apply to the whole target population. The high levels of exception reporting in relation to some of these processes when implemented singly were also noted as a concern.

Participants also expressed some anxiety as to how they could intervene where risk parameters were elevated; especially when this was related to medication e.g. raised BMI, suggesting that any potential indicator might need to be underpinned by practice education and support if health gains are to be achieved.

The indicator focusing upon CVD risk assessment was progressed to piloting.

Indicator wording as piloted

1. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses aged 25 to 84 years who have had a CVD risk assessment performed in the preceding 12 months.