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NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

INDICATOR DEVELOPMENT PROGRAMME

Consultation report on indicator(s)

Indicator area: Anxiety and depression

Consultation period: 26 January 2015 – 23 February 2015

Potential output: Recommendations for the NICE Menu for the Quality and Outcomes Framework (QOF)

Contents

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Indicators included in the consultation

ID	Indicator	Evidence source
IND-6	The percentage of patients with a new diagnosis of depression in the preceding QOF year whose notes record an offer of referral for psychological treatment within 3 months of the diagnosis	Recommendations 1.4.2.1, 1.4.2.2, 1.4.2.3, 1.4.2.4, 1.4.3.1, and 1.4.3.2 from the NICE guideline on depression in adults, recommendations 1.3.2, 1.3.4, 1.3.7 and 1.3.12 from the NICE guideline on common mental health disorders and quality statements 4, 6, 7, 8 and 13 from the NICE quality standard on depression in adults.
IND-7	The percentage of patients with a new diagnosis of anxiety in the preceding QOF year whose notes record an offer of referral for psychological treatment within 3 months of the diagnosis.	Recommendations 1.3.2, 1.3.4, 1.3.7 and 1.3.12 from the NICE guideline on common mental health disorders and statement 2 from the NICE quality standard on anxiety disorders.

Summary of consultation responses

Stakeholders were supportive of indicators around referral for psychological treatment for people with anxiety and depression. Public Health England (PHE) highlighted this corresponds with the priority areas identified for the QOF. There were however mixed opinions over whether 1 indicator was sufficient to cover both anxiety and depression or whether 2 separate indicators (1 for anxiety and 1 for depression) were required.

Some stakeholders however felt both indicators may be unnecessary as in their opinion people with anxiety and depression are already generally well managed.

The Royal College of Psychiatrists felt IND-6 and IND-7 should apply to all ages. They highlighted that NICE guidance supports the importance of psychological treatment for both children and adults.

Stakeholders suggested that limited spare capacity in psychological services may result in the service becoming overstretched should more people be referred.

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Comments by indicator (IND-6)

> *The percentage of patients with a new diagnosis of depression in the preceding QOF year whose notes record an offer of referral for psychological treatment within 3 months of the diagnosis*

Stakeholders highlighted potential problems with the timeframe of 3 months used for the piloted indicator. PHE commented that an offer of referral for psychological treatment should be made within 2 weeks of the diagnosis which is significantly less than the 3 month timeframe stipulated in this indicator. It was highlighted that the 3 month timeframe is not consistent with NHS England's 2020 commitment.

Problems with identifying the target population for the depression indicator were also highlighted. Stakeholders commented that depression is often recurrent and the distinction between a new episode and relapse is not clear, hence the target group can be ambiguous. This may mean that the indicator in its current form is not feasible and will need to be considered prior to recommending this indicator for the NICE menu.

Stakeholders commented that a lack in the availability of external psychological therapy in some areas may even mean this indicator would be unfeasible.

Comments by indicator (IND-7)

> *The percentage of patients with a new diagnosis of anxiety in the preceding QOF year whose notes record an offer of referral for psychological treatment within 3 months of the diagnosis.*

Stakeholders highlighted potential problems with the timeframe of 3 months used for the piloted indicator, suggesting that an offer of referral for psychological treatment should be made within 2 weeks of diagnosis which is significantly less than the 3 month timeframe stipulated in this indicator. It was highlighted that the 3 month timeframe is not consistent with NHS England's 2020 commitment.

Stakeholders including the RCGP also highlighted the need for careful consideration over the read codes used for IND-7 to ensure accurate reporting of the data. It was suggested that anxiety may require new Read codes as it is currently not included in the QOF.

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Specific issue for consideration during consultation

- For the purposes of piloting, referral for psychological treatment for anxiety and depression is covered under separate indicators. Are separate indicators for these 2 groups appropriate?

There were mixed responses from stakeholders in response to this question, but overall more stakeholders felt these indicators should be kept separate. Stakeholders commented that due to the fact the intensity/severity of condition and duration of treatment is different for both anxiety and depression these should be treated as separate indicators. Other stakeholders felt both conditions could be captured under a single indicator and it was also stated that anxiety and depression should be considered as part of a spectrum of diseases and not separate indicators.

Considerations for the Advisory Committee

The specific issues that the Advisory Committee is asked to consider when making recommendations on which indicators should be published on the NICE menu for the QOF are stated below.

These issues are also addressed in the indicator development reports which will include suggestions for possible amendments to how the indicators should be specified following piloting and public consultation.

The Advisory Committee is asked to consider:

- is there any value in having separate indicators for psychological treatment for anxiety and depression?
- would the available spare capacity in psychological services impact on the feasibility of these indicators?
- if the timeframe should be reviewed for these indicators?
- should these indicators apply to all ages or just adults?

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Appendix A: Consultation comments

Indicator ID	Stakeholder organisation	Comment
IND 6	Pennine Surgery	The local service currently have a long waiting list and by the time the patient hears anything from the service the crisis has passed if it is only something minor. There is a high percentage of DNA and also the local trust is running a self-referral scheme so the GPs will use this instead of having to complete the referral themselves.
IND 6	County Durham and Darlington Local Medical Committee	There is no need to have separate indicators for anxiety and depression for the purposes of piloting.
IND 6	South Cheshire and Vale Royal CCG's	I think these 2 groups should remain separate. All patients with anxiety should be referred for psychological treatments, however some depression is too severe to warrant early referral to these teams, and a referral urgently to a psychiatrist would be more appropriate. The psychiatrist could then determine when the patient was fit to have psychological input.
IND 6	Public Health England	Noting the current priority in attached to parity of esteem and the importance of strengthening mental health services in primary care it is recommended that an offer of referral for psychological treatment within 2 weeks of the diagnosis and not within 3 months of the diagnosis.
IND 6	NHS England and NHS Employers	There are a range of views with regards to the indicator in support of its implementation and against. These are conditions largely managed by practices and as the IAPT referral pathways are being increasing used then this indicator would be unnecessary. CCGs are locally promoting not just referral but also signposting to IAPT level one services i.e. self-care materials like the Northumberland workbooks or Big White Wall. The implementation of this indicator would interfere with the clinical judgement of the clinician.

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IND 6	East and North Hertfordshire CCG	Since a number of the QOF indicators are related to depression and anxiety but under a number of different headings, it would need to be clear how to code these patients in practice.
IND 6	British Medical Association	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.
IND 6	RCGP	This indicator seems to overlap with baseline GMS services? Depression is often recurrent and the distinction between a new episode and relapse is not clear, hence the target group can be ambiguous. Many are recorded as new episodes but in reality it is a relapsing rather than new problem. A three month window is inappropriate as the diagnosis may be gradual rather than a distinct onset, and many patients might prefer to try other self-help approaches initially, only wishing for further help if those do not work sufficiently. Hence the time limit is too restrictive. Our access to psychological therapies may be inadequate which would also make this a negative offer. In my area there is commonly a 12 month wait for psychological therapy and many patients are turned down by the service even when I do refer – not exactly a good offer to a patient with depression. We are concerned that this indicator should be piloted as it stands because the service being flagged up is too variable.

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IND 6	Yorkshire and Humber Commissioning Support Unit	Codes would be required for referral made, referral not wanted and referral not needed
IND 6	Royal College of Nursing	Question: For the purposes of piloting, referral for psychological treatment for anxiety and depression is covered under separate indicators. Are separate indicators for these 2 groups appropriate? Our staff and members consider that it would be appropriate to have separate indicators. Although these conditions can co-exist separate indicators would be a better way forward. Consideration should be given as to how services can offer treatment to those people who are housebound and those who also have cognitive impairment. Referral targets are inadequate and should be shorter.
IND 6	Lundbeck	The percentage of patients with a new diagnosis of depression in the preceding QOF year whose notes record an offer of referral for psychological treatment within 3 months of the diagnosis. Lundbeck strongly supports the inclusion of IND 6 in the QOF as an important standalone indicator. We believe that it is helpful to separate IND 6 and IND 7 for the purposes of piloting in order to clarify and simplify the process of providing suitable treatments for each condition for healthcare professionals. Lundbeck places the highest importance on the integration of mental health services and the support that primary care professionals receive to implement the NICE guideline recommendations. We believe that separate indicators for depression (IND 6) and anxiety (IND 7) will provide further clarity and support the implementation of treatment and referral (both pharmacological and non-pharmacological) for different severities of each condition, irrespective of age, location, gender, race, religion and sexual orientation. Furthermore, we believe that separate indicators for referral after a diagnosis of depression and anxiety (IND 6 and IND 7) are appropriate and would more effectively ensure maximum benefit for the patient based on their condition.

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IND 7	Public Health England	Noting the current priority attached to parity of esteem and the importance of strengthening mental health services in primary care it is recommended that an offer of referral for psychological treatment within 2 weeks of the diagnosis and not within 3 months of the diagnosis.
IND 7	NHS England and NHS Employers	See comments for indicator 6.
IND 7	East and North Hertfordshire CCG	The CCG wouldn't support anxiety as it is an arbitrary condition that affects people differently.
IND 7	British Medical Association	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.
IND 7	RCGP	GPs' access to psychological treatment is far too poor for this to be a feasible indicator. Many patients with anxiety prefer to try self-help initially and seek help if that is not effective so this time line of three months is too restrictive. Also the spectrum of patients reporting anxiety is very wide – some are acute or reactive problems which do not need referral. It is the persistence of symptoms that requires further action, not the initial diagnosis. (RP)
IND 7	Yorkshire and Humber Commissioning Support Unit	Anxiety is not currently included as a QOF disease area. Some work may need to be done by practices to ensure that the register is complete

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IND 7	Royal College of Nursing	Question: For the purposes of piloting, referral for psychological treatment for anxiety and depression is covered under separate indicators. Are separate indicators for these 2 groups appropriate? As above, yes separate indicators would be appropriate. Consideration should also be given as to how services can offer treatment to those people who are housebound and those who also have cognitive impairment. Referral targets are inadequate and should be much shorter.
I7	Institute of Primary Care & Health Sciences/ Arthritis Research UK Primary Care Centre, Keele University	We do not feel that these indicators need to be separated for anxiety and depression, anxiety and depression should be considered as part of a spectrum and not separate indicators. Agree that patients with a diagnosis should be offered a referral for psychological treatment but note that some patients do not want this. As a new indicator GPs may find access (wait times) to psychological therapies is a barrier for patients.
IND 6/7	South East Staffordshire & Seisdon Peninsular CCG	Would suggest that appropriate referral to psychological services should be captured under a single indicator. Clear exception reporting arrangements need to be considered- For example there will need to be some assurance that services providing psychological support have the ability to provide the care required in a timely fashion.
IND 6/7	Whitehall Surgery	Is there a need for an additional tick box? Already there is a code to review patients, actually 2, one regarding medication review, the other indicating interim review –understood as review of patients undergoing psychological therapy-. Considering that these services are already overstretched and clinicians already discuss with patient treatment options one has to fear some will interpret this indicator as a need to refer more people for psychological services, and to avoid exception reporting
IND 6/7	The Royal College of Psychiatrists - Faculty of Child and Adolescent Psychiatry	We would hope that QOF indicators 6 and 7 include all ages of patient and would encourage the consultation group to include in their list of evidence the NICE guidance on depression in children in young people (CG28, QS53, and CG31) relating to the management of anxiety disorder (including OCD) across the whole age range – this would ensure there is no misapprehension that these QOFs pertain only to adults.

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IND 6/7	Whalebridge Practice, Swindon and QOF Database Website	Psychological therapies are important. However in my area at least there is open access to these therapies and a referral is not required. I would suggest the wording is changed to purely document the offer of psychological therapies without specifically mentioning a referral. There is a strong overlap between anxiety and depression and separate indicators are likely to produce an artificial distinction. Many patients are diagnosed as "anxiety with depression" - would these patients appear in both indicators or just one, and if only one which one? I would suggest that these indicators are merged.
IND 6/7	Joint response from: Mind, Rethink Mental Illness, Centre for Mental Health, Mental Health Foundation, Mental Health Network and Royal College of Psychiatrists	For the purposes of piloting, referral for psychological treatment for anxiety and depression is covered under separate indicators. Are separate indicators for these 2 groups appropriate? We are commenting on both these indicators together as we believe their inclusion in the QOF is equally merited. Anxiety and Depression are different mental health conditions and although they can be experienced together as a form of 'mild to moderate' mental health problem, their underlying medical symptoms, causes and treatment can differ. Experiencing one condition over the other does not necessarily mean the other condition is unavoidable. We accept this indicator is for the purpose of piloting, but from experience we know that piloting at this stage sets the precedent for future indicators and for these reasons we strongly believe that both IND 6 and IND are 7 are crucial for inclusion in the QOF, and must be treated with equal weight by NHS England and CCGs. Our organisations frequently hear how difficult people find it to access services for their mental health. Despite the progress made since the introduction of the IAPT programme, we know that performance is varied across the country and that far too many people still face unacceptably long waits or are struggling to even get a referral. The recent We need to talk survey found that while waiting to access vital psychological treatment, many people become more unwell and one in six people attempt to take their own lives. The same survey also found that one in ten (9.6 per cent) are waiting over a year between referral and assessment, while four in ten (41 per cent) wait more than three months. Once

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		assessed, most people start therapy within three months, yet a third (32 per cent) wait longer. For this reason, we are seeking further clarity as to why this indicator is suggesting a time frame of three months for an offer of referral for psychological therapy once someone has been diagnosed with either depression or anxiety. This suggested waiting period is unacceptably long and puts people with a recent diagnosis of either anxiety or depression in an uncertain and further mentally challenging situation where their identified mental health problem is out at risk of exacerbating. The Government has recently committed to introducing the first waiting time standards in mental health, thus working towards achieving a parity of esteem for mental health. 'Achieving Better Access to Mental Health Services by 2020' set out NHS England's commitment to ensuring that 75 per cent of people referred to IAPT will be treated within 6 weeks of referral and 95 per cent will be treated within 18 weeks of referral. This inclusion of three months from diagnosis to referral – although measuring a different set of wait times than that proposed by NHS England – is still inconsistent with wait time standards which are described and adhered to elsewhere in the NHS for psychological therapies. We are concerned that this will create confusion thus leading to perverse incentives for commissioning access for first treatment, and unintended consequences which will have a detrimental impact on someone who has been newly diagnosed with either depression or anxiety. The QOF should complement the introduction of waiting and access standards for IAPT by incentivising referral to psychological therapies (whether based in IAPT services or otherwise) at the time of diagnosis (presuming that this takes place in primary care). This would not only be in line with the government's objective of reducing waiting times for psychological therapies, but also with the stated aim of the proposed QOF 'to ensure that GP teams know how to access different types of talking therapies locally and help people with depression decide on treatment options that are suitable for them.' The inconsistency between the proposed QOF and the government's intention to improve access to IAPT services must be removed or at the very least be clarified by NICE before it is accepted for the QOF. Collecting ongoing and consistent mental health data in primary care is essential. This is valuable for commissioners, policy makers, Government and people who use the service and

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		their family and/or carers. In order to understand referral rates, need for the service and plan better integrated care for improving services, it is fundamental that data for referral for anxiety and depression is collected to showcase whether one condition is referred more frequently to psychological therapies over the other and it's diagnosis prevalence within the CCG locality. This is another reason as to why separate indicators are needed for anxiety and depression. What (if any) are the potential unintended consequences that might result from implementing the indicators? As discussed above, we would not want IND 6 & 7 to negatively impact on people who are waiting to access psychological therapies at a time that is most crucial for them to gain the right therapy at the right time. Waiting too long to access vital psychological therapies can have hugely detrimental impact on someone's mental health and timely access can make the difference between recovery and experiencing a mental health crisis.
IND 6/7	British Geriatrics Society	Yes, as the intensity and duration of treatment varies for these two groups.
IND 6/7	RCGP	There are plenty of patients with such problems who can be dealt with by GPs without referral to other agencies. Once again if adopted it could well result in simply box-ticking, without any serious discussion about the patients' real, personal needs and how to address them. RCGP Overdiagnosis Group We are concerned about these indicators, as they do not account for tailoring the management according to both severity and patient preference. Whilst there is good evidence of the benefits of psychological therapies in moderate-severe depression and anxiety the evidence for mild disorders is much less clear. GPs do not normally (currently) differentiate by severity in their coding in mental health. The Readcodes used to define the groups would have to be very carefully considered as a result, as some widely used codes such as 'low mood', can be commonly used to indicate transient states as well as more significant problems. Our own work has shown UK GP coding of both anxiety and depression has changed over time with a drift towards using symptom codes. See Rait G, Walters K, Griffin M, Buszewicz M, Petersen I, Nazareth I. Recent trends in the incidence of recorded depression and depressive symptoms in primary care. Br J Psych 2009; 195: 520-524. doi:

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		10.1192/bjp.bp.108.058636 and Walters K, Rait G, Griffin M, Buszewicz M, Nazareth I. Incidence of anxiety diagnoses and symptoms recorded in primary care. PLoS One 2012, 7(8): e41670. doi:10.1371/journal.pone.0041670 We are not suggesting that we go back to recommending the use of the PHQ9 and GAD7 etc. in QOF, however there should be some consideration of severity in the recommendations that relate to treatment. We would therefore suggest that the indicator could be reworded e.g. "that the GP has offered the patient supported self-management with access to the relevant materials or referral to the appropriate psychological therapy service within 3 months of diagnosis, taking into account the severity of the problem and patient preference'.
IND 6/7	PHE Learning Disabilities Observatory	We are uncertain about these indicators. Anecdotal evidence suggests that there may be low recorded rates of depression as it appears in QOF in people with learning disabilities in order to keep this group of people out of the list for whom standard measures are applied (another QOF indicator). Agnostic on whether these need to be separate indicators or not (i.e. Anxiety separate from depression. The conditions have a lot of overlap and there is more diagnostic difficulty in people with learning disabilities. GPs may struggle to make such distinctions. Also – referral is one thing but some stuff I was involved in in Cumbria showed that people with learning disabilities, once referred to IAPT, were less likely to go to actually get an IAPT service, being signposted or referred back instead. So, disaggregate if possible, and accepted into some form of treatment within X months?
IND 6/7	Parkinson's UK	Parkinson's UK supports these indicators and the separation of depression from anxiety, as despite the two issues producing similar outcomes, they require different types of tailored care in order to improve mental and physical health outcomes. However, we strongly believe that this indicator could be further expanded to include all those people who have been diagnosed with a long-term condition being offered a referral to psychological treatment within three months of diagnosis. Research has demonstrated that there is a link between anxiety and the exacerbation of Parkinson's symptoms. For example, the disabling motor symptoms such as tremor, rigidity, bradykinesia, and postural instability, which often occur intermittently, have been shown to

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		increase when the person with Parkinson's is concentrating or feeling anxious. Major depressive disorder is common among people with Parkinson's. Research indicates that prevalence of depression may range from 8% in community-based patients to more than 20% in outpatient or inpatient settings, while depressive symptoms are even more common. Depression in Parkinson's is associated with a variety of poor outcomes for both patients and their families. Besides personal suffering, depression is related to greater disability, faster progression of physical symptoms, reduced cognitive performance, less ability to care for oneself, poorer adherence to treatment, poorer quality of life and increased distress in carers. Depression is also associated with increased mortality in Parkinson's patients and is the most important risk factor for suicide, especially after neurosurgical treatment of Parkinson's. Therefore, recognising and treating depression in the context of Parkinson's is vital to reduce disability and improve prognosis. We strongly urge NICE to expand the indicator to include all those people who have been diagnosed with a long-term condition being offered a referral to psychological treatment within 3 months of diagnosis. We believe this as the prevalence of depression and anxiety in Parkinson's and those with long-term conditions generally, coupled with the difficulty in identifying depression in Parkinson's means the clinical features overlap with the motor features of Parkinson's.

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Appendix B: Equality impact assessment for IND-6 and IND-7 (anxiety and depression)

Table 1

Protected characteristics
Age
Disability
Gender reassignment
Pregnancy and maternity
Race
Religion or belief
Sex
a) Sexual orientation
b) Other characteristics
Socio-economic status c) Depending on policy or other context, this may cover factors such as social exclusion and deprivation associated with geographical areas or inequalities or variations associated with other geographical distinctions (e.g. the North/South divide, urban versus rural).
Marital status (including civil partnership)
Other categories Other groups in the population experience poor health because of circumstances often affected by, but going beyond, sharing a protected characteristic or socioeconomic status. Whether such groups are identifiable depends on the guidance topic and the evidence. The following are examples of groups covered in NICE guidance: • Refugees and asylum seekers • Migrant workers • Looked after children • Homeless people.

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Indicator Equality Impact Assessment form

Development stage: Consultation

Topic: Anxiety and depression

1. Have relevant equality issues been identified during this stage of development? • Please state briefly any relevant issues identified and the plans to tackle them during development
No equality issues have been identified during this stage of the process.
2. Have relevant bodies and stakeholders with an interest in equality been consulted • Have comments highlighting potential for discrimination or advancing equality been considered?
Yes – stakeholders from all 4 UK countries were encouraged to comment on the potential new indicators as part of the NICE consultation and a wide group of relevant groups and organisations were contacted. Please refer to appendix A of the 'process report for indicators in development' for a full list of stakeholders consulted directly via email.
3. Have any population groups, treatments or settings been excluded at this stage in the process? Are these exclusions legal and justified? • Are the reasons for justifying any exclusion legitimate?
The proposed indicators cover people anxiety and depression. This reflects the condition-specific nature of most QOF indicators.
4. Do any of the indicators make it impossible or unreasonably difficult in practice for a specific group to access a test or intervention? • Does access to the intervention depend on membership of a specific group? • Does a test discriminate unlawfully against a group? • Do people with disabilities find it impossible or unreasonably difficult to receive an intervention?
No – comments from the consultation exercise do not suggest that the indicators will make it impossible or unreasonably difficult in practice for a specific group to access a test or intervention. However a stakeholder commented that due to the difficulties with the diagnosis of learning difficulties some GP's may find it difficult to identify these patients to refer them on to psychological treatment.
5. Do the indicators advance equality? • Please state if the indicator as described will advance equalities of opportunity, for example by making access more likely for certain groups, by tailoring the service to certain groups, or by making reasonable adjustments for people with disabilities?
There were no consultation comments to suggest that the indicators would necessarily advance equalities in terms of people with protected characteristics or other relevant characteristics.