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

Development feedback report on piloted indicators

QOF indicator area: Depression and anxiety

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 a new diagnosis of depression in the preceding QOF year whose notes record an offer of referral for psychological treatment within three months of the diagnosis.

Acceptability recommendation:

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

Implementation recommendation:

- Band 2

Band 2: minor problems identified during piloting or anticipated to arise in wider implementation. Problems resolvable prior to implementation through either 1) an amendment to indicator wording, 2) an amendment to the business rules and/or 3) by giving further clarification of indicator terms in associated guidance.

Cost effectiveness recommendation:

- Highly cost effective at a base case of 5 points.

Issues to consider:

Issue	Detail	Mitigating activity
Underlying register may not capture all patients with depression due to coding issues	Practices reported a tendency to code as low mood which was then reviewed at a later date. As QOF uses diagnostic codes to identify patients then those with symptom codes only will not be included.	
Practices unable to code when patients have been advised to self refer.		Explore potential for new Read code to capture this concept.
Timeframe for referral	Practices thought that this would be too soon for some patients to be thinking about making a self-referral	The Committee could consider extending the timeframe to 6 months.

Indicator

2. 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 three months of the diagnosis.

Acceptability recommendation

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

Implementation recommendation

- Band 2

Band 2: minor problems identified during piloting or anticipated to arise in wider implementation. Problems resolvable prior to implementation through either 1) an amendment to indicator wording, 2) an amendment to the business rules and/or 3) by giving further clarification of indicator terms in associated guidance.

Cost effectiveness recommendation

- Highly cost effective at a base case of 5 points.

Issues to consider:

Issue	**Detail**	**Mitigating activity**
Practices unable to code when patients have been advised to self refer.		Explore potential for new Read code to capture this concept.

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 a new diagnosis of depression in the preceding QOF year whose notes record an offer of referral for psychological treatment within three months of the diagnosis.
2. 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 three months of the diagnosis.

Assessment of clarity, reliability, feasibility, and acceptability

Clarity

No concerns noted during piloting or the GP focus group.

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
Need to check that the code clusters are still valid	There have been code releases since the pilot.	Need to carry out impact assessment
Is wording correct	'preceding QOF year'	Need clarification
Consider cross-year issues for patients diagnosed within last three months of the year.	Need to look back 15 months rather than 12 months in the second year of the indicator going live	Review business rules
Need to review all clusters	Clusters for both conditions similar and some codes missing	Evaluation of additional counts to inform review of clusters and possibly request codes for 'anxiety resolved' Also possibly request codes for general anxiety exceptions

Acceptability

The intent of these indicators and the inclusion of anxiety were generally well received even amongst practices that did not feel that they should be included in QOF.

Twenty-four practices (66.7%) thought that these indicators should be considered for inclusion in QOF, either as separate indicators (7 practices) or as a single indicator with a combined denominator (17 practices). A further two practices (5.6%) were ambivalent about their inclusion. Five practices (13.9%) did not think that these indicators should be considered for inclusion in QOF and one practice did not comment either way.

'I think it would be helpful to have it in QOF. It acts as incentive and a prompt and it, it is much more effective than medication…' (GP, Practice ID001)

'So, in, in principle, I really like the idea of, erm, bringing in anxiety to, to the, to the QOF, rather than just depression.' (GP, Practice ID023)

'…the thing about the psychological treatment is I think psychological treatment for these conditions is so valid that it's, it's probably important to have the pressure, the QOF pressure, almost, for the local erm teams to provide the services.' (GP, Practice ID019)

Eighteen practices (50%) reported that their current standard practice was to offer these patients psychological therapy. Only one practice reported that they had made changes to the care of these patients as a result of the pilot.

'We were already doing that. We are lucky enough to have a Depression and Anxiety Service, and we signpost it to the patients.' (GP, Practice ID006)

'It was quite positively received erm, because one of things that we know – we – we're not very good at is erm, erm, for various reasons, is using the talking therapies or counselling and things with these people and it allows us to say, 'Okay, well actually, I should be thinking about that too' and not necessarily just the medication. Erm, so that was very positive in that sense…' (GP, Practice ID001)

Of the practices who did not think this should be included in QOF the reasons given included concerns over offering this to all patients. Some practices noted that not all patients were suitable for psychological therapies and that in many cases the decision to offer this should be a clinical one. Concern was also expressed in relation to the timeframe for making the offer. A small number of practices noted that for some patients three months could be too soon to be making an offer of psychological therapy and suggested that this could be extended to six months. Practices who did not support inclusion in QOF also commented that they weren't sure incentivisation was necessary as this was happening anyway.

'If it's a severe presentation I think three months is too soon because by the time someone has come round to accepting that they might need an antidepressant and then started it and then got some benefit from it your three months has gone and there's no way that somebody can pick up the phone and self-refer themselves to TalkingSpace if they're so anxious that they can't even go to work or do anything else, keep their normal activities. So I, I think three months is a bit ambitious, to be honest.' (GP, Practice ID019)

All practices reported that they had access to psychological therapies, although issues were noted in relation to waiting times (especially for individual therapy following initial assessment) and patients preferring not to have group therapy. Some practices had in house counselling or CBT but most referred to a service outside the practice. Eighteen practices (50%) reported that access to these services was by patient self-referral and queried how this could be recorded. This concept was not supported during piloting and additional Read codes would be required.

'Ours are all done self-referral, so we do on our system, we print a form – here you are, that's the form – and the idea is that they are given one of those – you can take that away with you, okay? – they complete this, they send it off, it's all self-addressed, stamped addressed, look. [Okay] Okay? So the beauty about it is that they have to make a choice that they want to do it, so they have to be proactive themselves.' (GP, Practice ID005)

To be included in the denominator for these indicators patients needed to have been given a diagnosis of either depression or anxiety. Given the evidence which suggests that practice recording habits have changed in relation to this we asked practices about this. Nine practices (25%) reported that they used diagnosis codes. The remainder reported that they tended to use symptom codes such as 'low mood' to record the initial consultation which would be reviewed when the patient was

followed up and the diagnosis became clearer. Some practices noted that making a diagnosis, particularly of depression, could be challenging. Only one practice expressed a view about whether QOF should attempt to capture symptom codes, which was strongly negative. This is in line with the current views of coding experts that symptom codes should not be used as proxy measures of diagnoses.

'So, so we just use depression or anxiety or anxiety and depression and then if they don't come up for follow up and if – then they're given a phone call. If then they don't attend the phone call or not taking up their medication erm, after chasing up and things or if you make contact and they say, 'Actually, I'm much better. I don't need anything', then we add that as 'Depression resolved'.' (GP, Practice ID001)

'…so the reality is what – so what is depression? And what... and, you know … actually, a lot of the patients we see are actually, they're, they're in a temporary mood state, associated with life event.' (GP, Practice ID010)

Assessment of implementation

Assessment of piloting achievement

Indicator 1: New diagnosis of depression

DEPP906 INDICATOR	Baseline	Final
Number of Practices Uploading	**27**	**26**
Practice Population	204,852	198,058
Depression Register	14,828	14,834
Excluded regardless		
Rule 1 True (no recent diagnosis)	12,027	13,249
Excluded if they do not meet Numerator criteria		
Rule 3 True (recent registration)	117	68
Rule 4 True (depression exception)	44	19
Rule 5 True (recent diagnosis)	949	662
Total Exclusions	13,137	13,998
DEPP906 Denominator	1,691	836
DEPP906 Numerator	91	185
Numerator as % of Denominator	**5.38%**	**22.13%**

Indicator achievement rose by 16.75% during the pilot period. It is possible that this represents a change in recording habits rather than clinical practice. Most practices reported that they routinely offered patients the option of psychological therapies prior to piloting. At a practice level, final achievement ranged from 0% to 100% (median = 4.18%, IQR 0%: 32.65%).

Indicator 2: New diagnosis of anxiety

ANXP908 INDICATOR	Baseline	Final
Number of Practices Uploading	**27**	**26**
Practice Population	204,852	198,058
Anxiety Register	22,378	22,767
Excluded regardless		
Rule 1 True (no recent diagnosis)	19,731	21,224
Excluded if they do not meet Numerator criteria		
Rule 3 True (recent registration)	85	75
Rule 4 True (recent diagnosis)	559	650
Total Exclusions	20,375	21,949
ANXP908 Denominator	2,003	818
ANXP908 Numerator	76	160
Numerator as % of Denominator	**3.79%**	**19.56%**

Indicator achievement rose by 15.77% during the pilot period. It is possible that this represents a change in recording habits rather than clinical practice. Most practices reported that they routinely offered patients the option of psychological therapies prior to piloting but tended to record this as free text. At a practice level, final achievement ranged from 0% to 100% (median = 3.42%, Inter Quartile Range 0%: 28.34%).

Changes in practice organisation

No changes to practice organisation were reported. Practices did note that they would need to change their recording habits if this indicator was introduced into QOF. Many practices reported that access to psychological therapies was based upon self-referral and that they tended to record that the patient had been advised how to do this in free text rather than use a Read code.

Resource utilisation and costs

No increases in resource utilisation or costs were specifically noted, although there may be an effect upon access to psychological therapies if these indicators were to result in increased referral rates. However, given that most practices stated that an offer of psychological therapies was part of their routine care of these patients the risk of this is likely to be low.

Barriers to implementation

There are three main barriers to implementation. Firstly, not all patients require, or are felt to be clinically suitable, for psychological therapies. In some cases this assessment may change as the person becomes accepting of their diagnosis and responds to other treatment. Some practices felt that patients with more severe depression and anxiety should not be included in the denominator and that the three month timeframe for the offer of referral to be made might be too soon for some patients. Concern was expressed that this might lead to practices suggesting psychological therapies

at clinically inappropriate times in order to 'tick the box'. This could be mitigated to a certain extent by extending the time-frame for the offer of referral to be made. Six months was felt to be more acceptable, but even this may not account for all patients individual circumstances.

Secondly, most practices reported that access to psychological therapies was by self-referral and that there were no Read codes available to support this concept. These practices felt strongly that moving away from self-referral back towards GP referral would be a retrograde step and that instead the acceptable Read codes should incorporate the concept of self-referral.

Thirdly, given the different approaches described by practices to record symptoms and diagnoses it is possible that in practices who prefer to use symptom codes whilst they determine the diagnosis any denominator will be an underestimate of the patient population and difficult to compare in an meaningful way with practices who enter Read coded diagnoses earlier in the patient pathway.

The business rules will also need to be written to manage 'cross-year' issues so that patients who are diagnosed in the last 3 months of the QOF year whose referral could reasonably be made in the next QOF year are counted appropriately.

Assessment of exception reporting

Exception reporting was generally low with the exception of patients being excepted due to recent diagnosis. The Committee should be aware that under the QOF exception reporting criteria patients can be exception reported if their diagnosis was made in the last 3 months of the QOF year. This rule is applied automatically through the business rules unless the patient has received the care described in the indicator.

Assessment of potential unintended consequences

None identified.

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

None identified.

Suggested amendments to indicator wording

Given the challenges in practice to separating depression and anxiety we would recommend the creation of a single indicator as follows:

The percentage of patients with a new diagnosis of depression and/ or anxiety in the preceding QOF year, whose notes record an offer of referral for psychological treatment within three months of the diagnosis.

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

Following the June 2014 Advisory Committee meeting the NCCID was asked to develop new indicators for the management of depression.

Following discussion with Professor Antony Kendrick an indicator related to offering referral for psychological therapies was developed and discussed at a GP focus group.

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.

A potential indicator was shared with the group relating to the offer of referral for psychological therapies being given to patients with a new diagnosis of depression who are treated with anti-depressants. This was well received although the group queried why it was restricted to those treated with anti-depressants and felt that it should apply to all people with a new diagnosis. The group also suggested that a similar indicator should be piloted relating to the offer of referral for people with a new diagnosis of anxiety.

Both these indicators are to be progressed to piloting.

Indicator wording as piloted

1. 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 three months of the diagnosis.
2. 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 three months of the diagnosis.