

**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: 1<sup>st</sup> October 2013 – 31<sup>st</sup> March 2014**

**Potential output:** Recommendations for NICE menu

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## Summary of recommendations

### Indicator

1. The percentage of women with schizophrenia, bipolar affective disorder or other psychoses under the age of 45 years who have been given information and advice about pregnancy, conception or contraception tailored to their pregnancy and contraceptive intentions, recorded in the preceding 12 months.

### Acceptability recommendation:

- Band 4: <50% of practices support inclusion

### Implementation recommendation:

- Band 2/3

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.

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:

Unable to make an evaluation.

Issues to consider:

<b>Issue</b>	<b>Detail</b>	<b>Mitigating activity</b>
Coding issues	Condition specific codes for contraceptive, conception and pregnancy advice have been declined by UKTSC. Therefore in the pilot we used general codes for these concepts. Where patients have two conditions which require this advice e.g. diabetes and SMI then we will not be able to determine whether advice pertinent to both conditions was given.	
Small numbers at a practice level	Some practices may not have any patients eligible for the care described in this indicator.	

## 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

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  $\leq 10^{\text{th}}$  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 was extremely challenging. At the beginning of the pilot we had recruited 26 practices in England and 1 in each of the Devolved Administrations. Practice recruitment by strata is shown in the table below with cells in bold where we failed to meet target numbers.

	List size		
IMD Score	Low	Medium	High
Low	<b>2/3</b>	<b>3/4</b>	<b>2/5</b>
Medium	3/3	4/4	<b>3/4</b>
High	<b>3/4</b>	<b>3/4</b>	3/3

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Number of practices recruited: 29

Number of practices dropping out: 3

Number of practices interviewed: 26

[26 GPs, 8 practice nurses, 9 practice managers, 1 health care assistant and 5 administrative staff = 49 primary care staff most involved in QOF piloting]

All percentages reported have been calculated using the 29 practices recruited to the pilot as the denominator.

### **Piloted indicators**

1. The percentage of women with schizophrenia, bipolar affective disorder or other psychoses under the age of 45 years who have been given information and advice about pregnancy, conception or contraception tailored to their pregnancy and contraceptive intentions, recorded in the preceding 12 months.

### **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:

<b>Issue</b>	<b>Detail</b>	<b>Mitigating activity</b>
Coding issues	Condition specific codes for contraceptive, conception and pregnancy advice have been declined by UKTSC. Therefore in the pilot we used general codes for these concepts. Where patients have two conditions which require this advice e.g. diabetes and SMI then we will not be able to determine	

	whether advice pertinent to both conditions was given.	
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### Acceptability

Eight practices (27.6%) thought that this indicator should be considered for inclusion in QOF with a further five practices (17.2%) being ambivalent. Twelve practices (41.4%) did not think that this indicator should be considered for inclusion in QOF and one practice did not comment either way.

*“We think it’s very good, very helpful, for that patient group. Being able to help, er, advise for their, not ignore their, you know, their erm, family planning and er, sexual health. So it is important, yes.”* (GP25; ID25)

*“Erm, we probably should be doing it. It focuses us onto it and it, it’s clearly been identified as an area that could be improved on and there’s no harm in introducing that.”* (GP7; ID7)

*“My feeling was that this would be the sort of thing that I would address as a clinician with the individuals who happened to need it, not as a, a blanket that everybody should have this.”* (GP4; ID4)

Most practices felt that this was an important aspect of care which they thought should be addressed irrespective of whether it was included in QOF. Eleven practices reported that they had added a discussion of contraception and pregnancy to their mental health review template. However, practices were largely unconvinced of what would be gained by introducing this as a specific QOF indicator and further queried its introduction given the loss of indicators relating to contraceptive and pregnancy care in epilepsy and diabetes.

Difficulties were expressed in relation to engaging with this group of patients and then raising the topic within a consultation. A small number of practices expressed some discomfort with this, although in part this was due to them knowing their patients circumstances and feeling that the topic was currently inappropriate, coupled with some concern about how patients would react.

*“We just can’t get them to engage, can we? They’re just not going to engage in a conversation about their private life, you know.”* (GP7; ID7)

However, other practices commented that their patients were quite happy to discuss this and in some cases welcomed the opportunity. This was more likely to be the case in practices who had already integrated a discussion of contraception into their annual mental health review.

*“...getting those with the serious mental illness to have all the tests and assessments is a bit of a challenge, especially if they’re going to hospital out patients, again. Although I have to say, that, that in, in general, they were ok about it as part of the review.”* (GP19; ID19)

A small number of practices expressed the view that the primary role for the GP when a woman was either pregnant or wanting to plan a pregnancy was referring to her psychiatrist for specialist advice. They queried how inclusion in QOF would lead to better outcomes.

One practice expressed concerns that although this was an important aspect of care for these patients putting it in QOF may be counter-productive and lead to it being treated as a 'tick box' exercise.

*"So, does putting it in QOF mean that you would be doing things that you wouldn't be doing otherwise, ...or would it, is having it in there raising awareness in a useful manner, or is it just another box to tick, amongst the many boxes to tick?" (GP9, ID9)*

Practices did not express a view about the annual timeframe piloted, but this may have been because many of them had already integrated the discussion into the mental health annual review.

## Assessment of implementation

### Assessment of piloting achievement

MH INDICATOR	Baseline	Final
Number of Practices Uploading	<b>20</b>	<b>20</b>
Practice Population	165,048	165,692
Mental Health Register	1,395	1,450
<b>Excluded regardless</b>		
MH Rule 1 False: patient recorded as being 'in remission'	100	114
MH Rule 2 True: Male patients	672	714
MH Rule 3 True: Aged 45 years or over	381	382
MH Rule 4 False: patients who have had a hysterectomy	3	3
MH Rule 5 False: patients who have had a sterilisation	7	6
<b>Excluded if they do not meet Numerator criteria</b>		
MH Rule 7 True: exception reported for pregnancy/ contraception advice	0	1
MH Rule 8 True: registration in last 3 months	14	10
MH Rule 9 True: exception reported using generic MH exception codes	12	28
MH Rule 10 True: diagnosed in last 3 months	6	3
<b>Total Exclusions</b>	1,195	1,261
MH Denominator	200	189
MH Numerator	51	46
<b>Numerator as % of Denominator</b>	<b>25.50%</b>	<b>24.34%</b>

Achievement fell by 1.16% during piloting, although this may be due in part to the differences in timescales between the uploads. Baseline achievement was calculated over a 12 month period and

final achievement over the 6 months of the pilot only. At a practice level, final achievement ranged from 0% to 80% (median 20.71, IQR 7.5%; 36.43%).

### **Changes in practice organisation**

None identified. Practices tended to report addressing this at the patient's mental health review. Practices were less confident of the support available for women with an SMI who wished to plan a pregnancy with some uncertain about whether mental health issues could be addressed in their local pre-conception services. Most would refer patients back to their psychiatrist for specialist advice regarding medication management.

### **Resource utilisation and costs**

No resource implications identified. Most practices stated that they were already doing this as part of a mental health review.

### **Barriers to implementation**

The numbers of women eligible for this care at a practice level are small, averaging 10 per practice (range 1-42). Some practices may not have any patients for whom this care is relevant.

Some practices commented that this group can be difficult to engage with regarding reproductive issues, although this was concern was not universally expressed.

Pilot practices also noted that this aspect of care has been retired from epilepsy and not introduced in diabetes care and questioned why it was being considered here.

There may also be a need for practice education as to the relevance of pregnancy planning in particular for women not currently being prescribed psychotropic medication. Only eight practices demonstrated an awareness of the potential for relapse during pregnancy and the post-natal period in this group

### **Assessment of exception reporting**

Exception reporting was generally low (2.9%) once exclusions had been applied. The indicator as piloted required the most relevant piece of advice only to be given.

### **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**

None.

## **Appendix A: Indicator details**

At their June 2013 meeting the NICE Advisory Committee recommended that indicators be developed to reflect the following guideline recommendations:

SIGN Guideline 131 recommendation 7.5.1:

- All women with childbearing potential who take psychotropic medication should be made aware of the potential effects of the medications in pregnancy. The use of reliable contraceptive methods should be discussed.

NICE Guideline 38 recommendation 1.4.1.2:

- Contraception and the risks of pregnancy (including the risks of relapse, damage to the fetus, and the risks associated with stopping or changing medication) should be discussed with all women of child-bearing potential, regardless of whether they are planning a pregnancy. They should be encouraged to discuss pregnancy plans with their doctor.

NICE Guideline 45 recommendation 1.1.1.4:

- Healthcare professionals should discuss contraception and the risks of pregnancy (including relapse, risk to the fetus and risk associated with stopping or changing medication) with all women of child-bearing potential who have an existing mental disorder and/or who are taking psychotropic medication. Such women should be encouraged to discuss pregnancy plans with their doctor.

Four potential indicators were developed together with a list of associated issues to be discussed with Dr Irwin Nazareth and at a GP focus group prior to piloting (see table overleaf).

Recommendation	Potential indicator	Issues/ Questions
SIGN 131: 7.5.1: All women with childbearing potential who take psychotropic medication should be made aware of the potential effects of the medications in pregnancy. The use of reliable contraceptive methods should be discussed.	The percentage of women with an SMI who have been prescribed psychotropic medication in the preceding 12 months who have been advised of the risks of these medications during pregnancy.	What do we do with women who are recorded as being in recovery?
NICE CG38: 1.4.1.2: Contraception and the risks of pregnancy (including the risks of relapse, damage to the fetus, and the risks associated with stopping or changing medication) should be discussed with all women of childbearing potential, regardless of whether they are planning a pregnancy. They should be encouraged to discuss pregnancy plans with their doctor.	<p>The percentage of women with an SMI who have been advised of the risks of pregnancy in the preceding 12 months.</p> <p>The percentage of women with an SMI who have been pregnant in the preceding 12 months who have had their care plan updated to reflect their pregnancy and planned post-pregnancy care.</p>	<p>What do we mean by 'risks of pregnancy'?</p> <p>This could apply to all women with a recorded pregnancy irrespective of outcome.</p>
NICE CG45: 1.1.1.4: Healthcare professionals should discuss contraception and the risks of pregnancy (including relapse, risk to the fetus and risks associated with stopping or changing medication) with all women of child-bearing potential who have an existing mental disorder and/or who are taking psychotropic medication. Such women should be encouraged to discuss pregnancy plans with their doctor.	The percentage of women with an SMI under the age of 45 years who have been given information and advice about pregnancy, conception or contraception tailored to their pregnancy and contraceptive intentions recorded in the previous 12 months.	Mirror of new diabetes indicator.

### GP focus group

A GP focus group was held on 19<sup>th</sup> July 2013 where all potential indicators were discussed. Focus group attendees were volunteers recruited via the West Midlands Faculty of the RCGP. Over 100 GPs responded to the initial invitation. From this group we purposively selected 10 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. Half were male. Six of the 10 were GP partners. The majority of participants described themselves as being of white ethnicity (n=6). A GP registrar attended the meeting as an observer. Participants were reimbursed £250 for their attendance.

Daniel Sutcliffe, Gavin Flatt and Laura Hobbs attended on behalf of NICE and Paul Amos for the NHS HSCIC.

Indicator discussions are summarised below:

Recommendation	Potential indicator	Issues/ Questions	Decisions post focus group
SIGN 131: 7.5.1: All women with childbearing potential who take psychotropic medication should be made aware of the potential effects of the medications in pregnancy. The use of reliable contraceptive methods should be discussed.	The percentage of women with an SMI who have been prescribed psychotropic medication in the preceding 12 months who have been advised of the risks of these medications during pregnancy.	What do we do with women who are recorded as being in recovery?	Why limit to women with an SMI? What about women prescribed SSRIs? Who should perform this? What risks are we talking about? Area of uncertainty for GPs.  Could be progressed to piloting.
NICE CG38: 1.4.1.2: Contraception and the risks of pregnancy (including the risks of relapse, damage to the fetus, and the risks associated with stopping or changing medication) should be discussed with all women of childbearing potential, regardless of whether they are planning a pregnancy. They should be encouraged to discuss pregnancy plans with their doctor.	The percentage of women with an SMI who have been advised of the risks of pregnancy in the preceding 12 months.  The percentage of women with an SMI who have been pregnant in the preceding 12 months who have had their care plan updated to reflect their pregnancy and planned post-pregnancy care.	What do we mean by 'risks of pregnancy'?  This could apply to all women with a recorded pregnancy irrespective of outcome.	Do not progress to piloting.  Care plans may exist but not used.  What are the risks of pregnancy? Again GPS uncertain in this area about how they would advise women.
NICE CG45: 1.1.1.4: Healthcare professionals should discuss contraception and the risks of pregnancy (including relapse, risk to	The percentage of women with an SMI under the age of 45 years who have been given information and advice about	Mirror of new diabetes indicator.	Could go forward to piloting.  General plea to keep indicators simple.

the fetus and risks associated with stopping or changing medication) with all women of child-bearing potential who have an existing mental disorder and/or who are taking psychotropic medication. Such women should be encouraged to discuss pregnancy plans with their doctor.	pregnancy, conception or contraception tailored to their pregnancy and contraceptive intentions recorded in the previous 12 months.		
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Two indicators were identified as having potential for piloting. This was later reduced to one on the advice of Dr Nazareth.

#### **Indicator wording as piloted**

- The percentage of women with an SMI under the age of 45 years who have been given information and advice about pregnancy, conception or contraception tailored to their pregnancy and contraceptive intentions recorded in the previous 12 months.