

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

Development feedback report on piloted indicators

QOF indicator area: Influenza Vaccination

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

Potential output: Recommendations for NICE menu

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Summary of recommendations

Indicator

1. The percentage of patients with coronary heart disease, stroke or TIA, diabetes and/ or COPD who have had an influenza vaccination in the preceding 1 August to 31 March.

Acceptability recommendation:

- Band 4: <50% of practices support inclusion.

Implementation recommendation:

- Band 1: no problems identified during piloting or anticipated to arise. Indicator terms precisely defined.

Cost effectiveness recommendation:

- Highly cost effective at the base case of 7 points.

Issues to consider:

Issue	Detail	Mitigating activity
Need to ensure practices can easily track achievement on the indicator for the different conditions	Flu vaccinations for each condition may be managed by a different member of staff who would need to be able to track uptake rates for each condition.	None suggested. This is more of a monitoring than a measurement issue.

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.

Number of practices recruited:	36
Number of practices who dropped out during piloting:	1
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 coronary heart disease, stroke or TIA, diabetes and/ or COPD who have had an influenza vaccination in the preceding 1 August to 31 March.

Assessment of clarity, reliability, feasibility, and acceptability

Clarity

No major problems with ambiguity noted during the GP focus group or with pilot practices.

Reliability and feasibility

Business rules were developed to support this indicator.

Issues to be resolved before implementation

Issue	Detail	Mitigating activity
Need to check that the code clusters are still valid	There have been code releases since the pilot. For example there is now a COPD resolved code	Need to carry out impact assessment
Need to ensure comparable with other clusters in other vaccine services	There are enhanced services that also incentivise flu vaccinations	Review all similar specifications

Acceptability

Practices were divided in their views as to whether this indicator should be incentivised. Twelve of the pilot practices (33.3%) felt that this should be considered for inclusion in QOF, two of which stated yes as long as the points were not reduced. A further seven practices (19%) were ambivalent. Thirteen practices (36%) did not support it being considered for inclusion, with most of these stating that they should be kept as individual indicators.

Almost all practices agreed with the general view that the influenza vaccination should be incentivised in QOF. Two practices felt the influenza vaccination should be taken out of QOF completely. It was noted that uptake of the vaccination had reduced recently due to negative media reporting. There was also some confusion over the criteria for exception reporting for this indicator, where some practices believed people could not be exception reported if they chose not to have the vaccination, which is not the case. This confusion could have arisen due to influenza vaccination being supported both through QOF and an Enhanced Service. These funding mechanisms have different rules regarding the discounting of patients from their respective denominators.

"I don't know that it should be in QOF because it's already part of Public Health, isn't it? So I don't think it should." (Admin staff, Practice ID009)

"It's not very professional and I mean there is no exception coding, the only thing that they can, er, we can say that they've declined but that does not knock them off that indicator, they either have the vaccine or they have, they can't have it because they've got an egg allergy, there is nothing else. So it doesn't take into consideration, it's quite prejudiced actually because it doesn't take into consideration you know people's opinions and whether they actually feel it will benefit them whether they want it." (GP, Practice ID003).

"Well some of these indicators are 93 and 95% which gives no margin for anybody to look up and say actually I don't want the flu jab and that's my prerogative I mean I think one of them's 98%." (GP, Practice ID003)

Thirteen practices (36%) expressed a dislike of including a composite indicator in QOF. Most practices felt combining the indicators may lead to a reduction in pay and QOF points which wouldn't account for the workload involved. This reduction in points may act as a disincentive for some practices.

“The risk of losing the points, yes because [of course, yeah] it’s crazy to, to do that. I mean we’ve seen that happen in the past.” (GP, Practice ID001)

So, that will just be a manoeuvre to [hmm] cut the amount of points that get attributed to it, and therefore, cut the funding. So, no.” (GP, Practice ID006)

“I think if, by amalgamating everything, that your overall work on that specific area of activity reduces, then the impact might well be that practices, you know, may then decide, well, where are our priorities in terms of capacity, time and input and the return on that, so.” (GP, Practice ID018)

Concern was also expressed that combining the indicators could make monitoring of vaccination coverage more difficult at a practice level. Some practices had a designated nurse or other member of staff for each disease group who were good at following up with patients who hadn’t attended for their flu vaccination. Combining the indicators would make it more challenging to identify which conditions were not achieving well.

“Yes, they are very good at chasing up their individual, because they can identify which of their patients haven’t had their flu, so they’re good at sort of chasing them up, whereas if it’s en masse and they can’t see how well their clinic’s doing or their, their patient group are doing, there isn’t that much incentive or driver to... “ (GP, Practice ID002)

“You know, as long as you keep the conditions separate and you’ve got your registers for CHD, you’re doing your reviews for that and it doesn’t impact on that, but it, it may well confuse it a little bit because you’ve got your separate registers, you call the patient in for the flu, and you’re able to target that cohort of patients; that’s how we work, isn’t it? You’ve got your diabetes list, you’ll pull that off, you’ll have your COPD list, you’ll pull that off, and then say ‘right, these guys haven’t had their flus; I need to do their reviews’. So you” (GP, Practice ID004)

Another criticism of using a composite indicator was it assumes each of the individual indicators were of equal importance and one practice felt COPD patients needed the flu vaccination more than the other disease groups.

“My view is that what you’re saying by combining them is they are equally important, and I am not sure they are equally important. I think the COPD ones are more important, personally.” (GP, Practice ID005)

“I wonder if people with asthma and COPD should have a separate indicator [yeah] – stay as a separate indicator for people with respiratory predisposing factors?” (GP, Practice ID001)

Eleven practices (31%) felt the composite indicator could be included in QOF with two stating that they felt the indicators should be combined only if points and pay were not reduced. A further seven practices were ambivalent. Most of these practices hadn’t considered the possibility that QOF points and pay may be reduced through combining the indicators and didn’t explore this. Benefits of

combining the indicators were mainly administrative where several practices thought achievement would be easier to track if there was a combined indicator. Many practices stated that it didn't make a difference if whether the indicators were combined or kept separate because they do this anyway as standard practice.

"I can't see a clinical consequence from one another really, it's just sort of the way the information is presented isn't it" (GP, Practice ID015)

"Erm, so – in which case, you know, they have one list and they're not having to check multiple different lists and work out where we've up to and how many vaccines we've got left in and all that kind of stuff." (Practice Nurse, Practice ID011)

"Administratively it'd probably make it easier, because we're not having to look, on the QOF you're not looking at different searches where obviously some of the people are in more than one, one group." (Practice Manager, Practice ID010)

Assessment of implementation

Assessment of piloting achievement

FLU INDICATOR	Baseline	Final
Number of Practices Uploading	26	26
Practice Population	197,628	198,058
Immunisation Register	17,701	19,164
Excluded regardless		
Excluded if they do not meet Numerator criteria		
Rule 2 True (recent registration)	130	93
Rule 3 True (recent diagnosis)	153	185
Rule 4 True (permanent contraindication)	22	23
Rule 5 True (temporary contraindication)	2,094	2,601
Total Exclusions	2,399	2,902
IMMUP903 Denominator	15,302	16,262
IMMUP903 Numerator	13,954	15,036
Numerator as % of Denominator	91.19%	92.46%

Baseline achievement was calculated over 8 months, including the 2013/14 flu vaccination season and final achievement over an 8 month period, which included the 2014/15 flu vaccination season. During piloting baseline achievement ranged from 79.4% to 100% (median = 93.26%, Inter Quartile Range (IQR) 88.6%; 96.38%) and final achievement from 78.7% to 98.3% (median = 95.52%, IQR 92.57%; 96.64%).

Changes in practice organisation

No practices reported needing to make any changes to the organisation of care. The influenza vaccination is currently incentivised for each condition.

Resource utilisation and costs

Concerns were raised about potential loss of resources if QOF points were reduced, although this is primarily an issue for negotiations.

Barriers to implementation

No specific barriers to implementation were reported.

Assessment of exception reporting

The impact on exception reporting is anticipated to be minimal as a result of combining these indicators. Reported exception reporting at the final data collection was 15.1%. At the baseline data collection it was 13.6% which is broadly comparable to the England level published rates for the individual indicators during the same period (CHD = 13.52, Stroke/TIA = 16.49, COPD = 14.83 and Diabetes = 16.11).

Assessment of potential unintended consequences

Practices expressed some concerns that if the QOF points and payment were reduced this may have a demotivating effect on practices.

Some practices suggested it may be more difficult to track the flu vaccination rates by condition if they were combined to a single indicator.

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

This indicator will combine the following indicators currently in QOF:

CHD007: The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 August to 31 March.

STIA009: The percentage of patients with stroke or TIA who have had influenza immunisation in the preceding 1 August to 31 March.

DM018: The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 August to 31 March.

COPD007: The percentage of patients with COPD who have had influenza immunisation in the preceding 1 August to 31 March.

Suggested amendments to indicator wording

The Committee may wish to use this opportunity to bring the incentivised time period in QOF into line with that in the DES, i.e. 1 September to 31 March.

Appendix 1: 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 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 it was agreed to explore the potential to combine the four existing influenza vaccination indicators into a single indicator. This was drafted and potential issues highlighted in the table below for discussion with a group of front line GPs.

Recommendation	Potential indicator	Issues/ Questions
Consider the development of an overarching influenza immunisation indicator.	The percentage of patients with coronary heart disease, stroke or TIA, diabetes and/or COPD who have had an influenza vaccination in the preceding 1 August to 31 March.	Are there any unintended consequences to this in terms of: <ul style="list-style-type: none"> • Disadvantaged groups • Maintaining immunisation levels?

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.

One indicator was presented which represents a bundling of the current QOF conditions for which influenza vaccination is incentivised individually. Participants were largely ambivalent about this change although they noted that it does not include those groups most at risk of influenza and associated morbidity and mortality who also tend to have lower immunisation rates. These groups are covered in the DES and there was little interest in recreating the DES within QOF.

This indicator was progressed to piloting, although it should be noted that any differential effect upon immunisation coverage of people with the different conditions will not be identified by piloting due to practices currently being incentivised for disease specific coverage.

Indicator wording as piloted

1. The percentage of patients with coronary heart disease, stroke or TIA, diabetes and/ or COPD who have had an influenza vaccination in the preceding 1 August to 31 March.