NHS England

CCG data collection for people with severe mental illness receiving a full physical health check and follow-up interventions in primary care

Technical guidance

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1 Technical definition

1.1 Overview

In 2016, the Five Year Forward View Mental Health (MHFYFV) set out NHS England's approach to reducing the stark levels of premature mortality for people living with severe mental illness (SMI) who die 15-20 years earlier than the general population, largely due to preventable or treatable physical health problems.

In the MHFYFV, NHS England committed to leading work to ensure that "by 2020/21, 280,000 people living with SMI have their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention each year". This equates to a target of 60% of people on the General Practice SMI register receiving a full and comprehensive physical health check and the required follow up care. This commitment was reiterated in the Next Steps on the NHS Five Year Forward View.

Whilst physical health checks may be delivered in either primary or secondary care, **this specific indicator will measure the number and percentage of people on General Practice SMI registers who are receiving a comprehensive physical health check in primary care settings only**. Please note that the delivery of health checks in secondary care is reported separately via the Improving physical healthcare to reduce premature mortality in people with serious mental illness (PSMI) CQUIN and associated audit.

This indicator asks CCGs to report quarterly on the delivery of physical health checks for people on the SMI register in primary care. This indicator specifies national reporting on a subset of elements of the comprehensive physical health check in 2018/19 and asks CCGs to undertake developmental work in 2018/19 to locally record the additional elements of the comprehensive check and, where indicated by the comprehensive assessment, to record and monitor the delivery of associated follow-up interventions, in line with the relevant NICE guidelines. It is anticipated that from 2019/20 all elements of the physical health check and subsequent intervention data will be collected nationally.

1.2 Indicators and calculations

1.2.1 Part 1 – the standard:

Denominator: The total number of people on the General Practice SMI registers (on the last day of the reporting period) excluding patients recorded as 'in remission'.

As per QoF Guidance, the SMI register includes all patients with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy. QoF Guidance documents contain detail on when clinicians should consider excluding patients from the SMI register because their illness is in remission.

Numerator: Out of the denominator, the number of people who have received a comprehensive physical health assessment (i.e. all of the checks 1-6 below) in the 12 months to the end of the reporting period, delivered in a primary care setting.

1.2.2 Part 2 – supporting measures:

Denominator: The total number of people on the General Practice SMI registers (on the last day of the reporting period) excluding patients recorded as 'in remission'.

As per QoF Guidance, the SMI register includes all patients with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy. QoF Guidance documents contain detail on when clinicians should consider excluding patients from the SMI register because their illness is in remission. This is the denominator for all 6 measures in this section and is the same as the denominator for part 1.

Numerators:
Of the denominator, the number of people who have received each of the following elements of the physical health check(s) in the 12 months to the end of the reporting period, delivered in a primary care setting:

1. a measurement of weight (BMI or BMI + Waist circumference)
2. a blood pressure and pulse check (diastolic and systolic blood pressure recording + pulse rate)
3. a blood lipid including cholesterol test (cholesterol measurement or QRISK measurement)
4. a blood glucose test (blood glucose or HbA1c measurement)
5. an assessment of alcohol consumption
6. an assessment of smoking status

Note that a person who has received all elements of the physical health check would be reported in all of the individual numerators.

It is recognised that people will have been on the GP SMI register for different durations and that some people may have had limited opportunity to be offered physical health checks in primary care; this is considered an acceptable limitation of the data collection.

Calculations: Utilising the numerator and denominator definitions above, the percentage of people receiving health checks will be calculated as:

$$\% = 100 * \frac{Numerator}{Denominator}$$

For the purpose of indicator Part 1, a person is counted as having had a comprehensive physical health assessment if they have received all of the component parts listed in Part 2 at any point in the12 months to the end of the reporting period.

Further details: NHS England guidance document *Improving physical healthcare for people living with severe mental illness in primary care* emphasises that the following

elements must be provided for people with SMI as part of a comprehensive health check, in line with clinical evidence and consensus:

1. *an assessment of nutritional status, diet and level of physical activity*
2. *an assessment of use of illicit substance/non prescribed drugs*
3. *access to relevant national screenings*
4. *medicines reconciliation and review*
5. *general physical health enquiry including sexual health and oral health*
6. *indicated follow-up interventions*

1.3 Codes for reporting:

Information on the codes associated with each element of the physical health check to be reported in 2018/19 is set out in the tables below. Where alternative codes are routinely used to record the required elements of the health check, CCGs can undertake a local exercise to map these to the codes provided in this guidance.

1.3.1 A measurement of weight (BMI or BMI + Waist circumference)

For this data item, CCGs should report on **EITHER** the number of people who have had a measurement of BMI **OR** the number of people who have had a measurement of BMI plus a measurement of waist circumference.

	READ V2 code (provided to support transition to SNOMED CT)	CTv3 code (provided to support transition to SNOMED CT	SNOMED CT code
Measurement of body mass index	22K..	22K.. Xa7wG X76CO	60621009 Body mass index (observable) *Observable codes should be used for SNOMED enabled systems. Due to current mapping processes, CCGs may also wish to include the relevant finding code for reporting:* 301331008 Finding of body mass index (finding)
Measurement of waist circumference	22N0.	Xa041	276361009 Waist circumference (observable)

1.3.2 A blood pressure and pulse check

For this data item, CCGs should report on the number of people who have had a diastolic blood pressure recording **AND** a systolic blood pressure recording **AND** a measurement of pulse rate.

	READ V2 code (provided to support transition to SNOMED CT)	CTv3 code (provided to support transition to SNOMED CT	SNOMED CT code
Diastolic blood pressure reading	246A.	246A.	1091811000000102 Diastolic arterial pressure (observable) *Observable codes should be used for SNOMED enabled systems. Due to current mapping processes, CCGs may also wish to include the relevant finding code for reporting: 163031004 On examination - Diastolic blood pressure reading (finding)*
Systolic blood pressure reading	2469.	2469.	72313002 Systolic arterial pressure (observable) *Observable codes should be used for SNOMED enabled systems. Due to current mapping processes, CCGs may also wish to include the relevant finding code for reporting: 163030003 On examination - Systolic blood pressure reading (finding)*

	READ V2 code (provided to support transition to SNOMED CT)	CTv3 code (provided to support transition to SNOMED CT	SNOMED CT code
Pulse rate	242.. 242Z.	242.. X773s XaIBo	78564009 Heart rate measured at systemic artery (observable entity) 8499008 Pulse, function (observable entity) *Observable codes should be used for SNOMED enabled systems. Due to current mapping processes, CCGs may also wish to include the relevant finding code for reporting:* 162986007 *On examination - pulse rate (finding)*

1.3.3 A blood lipid including cholesterol test

For this data item, CCGs should report on the number of people who have either had a cholesterol level recording **OR** have had a QRISK measurement recorded.

	READ V2 code (provided to support transition to SNOMED CT)	CTv3 code (provided to support transition to SNOMED CT	SNOMED CT code
Cholesterol measurement	Refer to cholesterol QoF cluster for reporting. Visit the NHS Digital website and click on 'Download the QOF V39 draft expanded cluster list for publication'.		
QRISK measurement	22W.. 38DP. 8IEL. 8IEV. 9NSB.	XaYZR XaQVY XaYzy XaZdA XaZd8	810931000000108 QRISK2 calculated heart age (observable entity) 718087004 QRISK2 cardiovascular disease 10 year risk score (observable entity)

	READ V2 code (provided to support transition to SNOMED CT)	CTv3 code (provided to support transition to SNOMED CT	SNOMED CT code
			822541000000103 QRISK cardiovascular disease risk assessment declined (situation) 847241000000100 QRISK2 cardiovascular disease risk assessment declined (situation) 847201000000103 Unsuitable for QRISK2 cardiovascular disease risk assessment (finding)

1.3.4 A blood glucose test

For this data item, CCGs should report on the number of people who have had any of the following blood glucose measurement recordings OR HbA1c measurement.

	READ V2 code (provided to support transition to SNOMED CT)	CTv3 code (provided to support transition to SNOMED CT	SNOMED CT code
Blood glucose measurement	44g.. 44TA. 44g1. 44TJ. 44U.. 44f.. 44f1. 44T2.	XM0ly 44g1. X772z 44f.. 44f1. XE2mq XE2q9	1010671000000102 Plasma glucose level (observable entity) 1003141000000105 Plasma fasting glucose level (observable entity) 997671000000106 Blood glucose level (observable entity) 1010611000000107 Serum glucose level

	READ V2 code (provided to support transition to SNOMED CT)	CTv3 code (provided to support transition to SNOMED CT	SNOMED CT code
	44TK. 44Q..		(observable entity) 1003131000000101 Serum fasting glucose level (observable entity) 997681000000108 Fasting blood glucose level (observable entity) 1005691000000109 Serum triglycerides level (observable entity)
HbA1c measurement	42W.. 42WZ. 42W4. 42W5.	42WZ. XE24t XaERp XaPbt	269823000 Haemoglobin A1C - diabetic control interpretation (observable entity) 1019431000000105 Haemoglobin A1c level (Diabetes Control and Complications Trial aligned) (observable entity) 999791000000106 Haemoglobin A1c level - International Federation of Clinical Chemistry and Laboratory Medicine standardised (observable entity)

1.3.5 An assessment of alcohol consumption

For this data item, CCGs should report on the number of people who have had an alcohol consumption recording.

	Information on codes
Alcohol consumption assessment	Run alcohol consumption QoF cluster for reporting. *Visit the NHS Digital website and click on 'Download the QOF V39 draft expanded cluster list for publication'.*

1.3.6 An assessment of smoking status

For this data item, CCGs should report on the number of people who have had a smoking assessment recording. Please run smoker/ex-smoker/current smoker/smoking habit/never smoked QoF clusters for reporting.

	Information on codes
Smoking status assessment	Run smoker/ex-smoker/current smoker/smoking habit/never smoked QoF clusters for reporting. *Visit the NHS Digital website and click on 'Download the QOF V39 draft expanded cluster list for publication'.*

1.4 To be monitored locally in 2018/19:

As set out above, the following additional elements must be provided for people with SMI as part of a comprehensive health check in line with clinical evidence and consensus, and these elements will be built into national reporting and monitoring in future years:

1. *an assessment of nutritional status, diet and level of physical activity*
2. *an assessment of use of illicit substance/non prescribed drugs*
3. *access to relevant national screenings*
4. *medicines reconciliation and review*
5. *general physical health enquiry including sexual health and oral health*
6. *indicated follow-up interventions*

Data on these six additional elements will not be captured nationally in 2018/19. CCGs should locally record and monitor take-up of NICE recommended interventions (for example 'referral to smoking cessation'), and should undertake developmental work in 2018/19 to enable system reporting of all elements of the comprehensive health check in future years (for example, CCGs can work to improve local recording of 'no history of substance misuse' to enable monitoring of this element of the health check moving forward).

2 Monitoring

2.1.1 Monitoring Frequency:

Quarterly

2.1.2 Monitoring Data Source:

This indicator will be monitored via the new SMI data collection, which is to be set up via the Strategic Data Collection Service (SDCS). Data breaches will be captured and recorded according to SDCS protocols.

The collection will capture the numerators and denominators required for the indicators described in parts 1 and 2. Data related to interventions should be collected and monitored locally.

CCGs will be required to obtain data on delivery of physical health checks from their commissioned provider of this activity within primary care. This technical guidance provides a list of the appropriate codes to support reporting.

The first CCG submission is expected in October 2018 and will cover the 12 month period until the end of September 2018, and then quarterly thereafter in line with the SDCS schedule.

It is expected that data will be transmitted from NHS Digital to NHS England following the standard mechanism for SDCS data collections. Analysis will be undertaken by NHS England and published at national and CCG levels. It is expected that data will be published as official statistics, in line with the NHS England publication schedule, when the data is considered to be of sufficient quality.

3 Accountability

3.1.1 What success looks like

The expectation for this indicator is that 50% of people on GP SMI registers will receive a full and comprehensive physical health check in a primary care setting during 2018/19.

Together with the expected numbers of people receiving a comprehensive physical health check in secondary care (expected to be 10%), this will contribute to the overall ambition that 60% of people on GP SMI registers will receive a full and comprehensive physical health check and the required follow up in 2018/19.

3.1.2 Rationale

People with SMI are at increased risk of poor physical health. The life-expectancy of the SMI cohort is reduced by an average of 15–20 years compared to the general population, mainly due to preventable physical illness. Two thirds of these deaths result from avoidable conditions, including heart disease and cancer, primarily caused by smoking. Current barriers in access to physical healthcare for people with mental health problems are highlighted by the observation that less than a third of people with schizophrenia treated in hospital settings receive the recommended cardiovascular risk assessment across the 12 months leading to admission. People with SMI are three times more likely to attend A&E with an urgent physical health need and almost five times more likely to be admitted as an emergency case, suggesting deficiencies in the primary physical healthcare they are receiving.

Best practice evidence indicates that where primary care teams deliver care collaboratively with secondary care services, outcomes are improved. The lead responsibility for assessing and supporting physical health will transfer depending on where an individual is in their pathway of care, as set out in NICE guidelines CG 185 and CG 178:

Primary care teams are responsible for carrying out annual physical health assessments and follow-up care for:

1. patients with SMI who are not in contact with secondary mental health services, including both:
    a. those whose care has always been solely in primary care, and
    b. those who have been discharged from secondary care back to primary care; and
2. patients with SMI who have been in contact with secondary care mental health teams (with shared care arrangements in place) for more than 12 months and / or whose condition has stabilised.

Secondary care teams are responsible for carrying out annual physical health assessments and follow-up care for:

1. patients with SMI under care of mental health team for less than 12 months and / or whose condition has not yet stabilised
2. inpatients.[1]

[1] NICE clinical guidance **CG178**