NHS
Oxfordshire
Clinical Commissioning Group

OCCG SERVICE SPECIFICATION (2019/20)

PRIMARY CARE SERVICE FOR THE PROVISION OF IMPROVING PHYSICAL HEALTH IN PATIENTS WITH A SEVERE MENTAL ILLNESS

1. Introduction

People living with severe mental illness (SMI) face one of the greatest health inequality gaps in England. This population group is at risk of dying on average up to two decades earlier than the general population, mostly due to preventable physical diseases. This disparity in health outcomes is partly due to physical health needs being overlooked, both in terms of identification and treatment. These patients should be actively screened for preventable health conditions relating to a lack of physical activity, smoking and alcohol, such as obesity, diabetes, heart disease and cancer.

The life expectancy of people with SMI, such as schizophrenia or bipolar affective disorder, is lower by an average of 15–20 years compared to the general population due to preventable physical illness. In Buckinghamshire; patients with SMI are 3.5 x more likely to die prematurely.

- Smoking is the largest avoidable cause of premature death and health inequality in those with mental disorders, with individuals with SMI being three times more likely to smoke.
- Individuals with SMI have double the risk of obesity and diabetes,
- Individuals with SMI have three times the risk of hypertension and metabolic syndrome,
- Individuals with SMI have five times the risk of dyslipidaemia than the general population.

All adults on the SMI register should receive the full list of recommended physical health assessments as part of a routine check at least annually (NICE clinical guidelines CG185 and CG178).

In the Five Year Forward View for Mental Health, NHS England committed to ensure that "by 2020/21, 280,000 more people living with severe mental illness (SMI) have their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention each year".

NHSE targets:

- 2017/18 30% of patients with SMI to have an annual health check
- 2018/20 60% of patients with SMI to have an annual health check (at least 50% in primary care and 10% in secondary care)

Patients with SMI are part of a QoF population monitored and although the QoF Guidance suggests comprehensive health checks are the aim, QoF only monitors a subset of the data which is needed to be recorded. QoF SMI represents 26 points or approximately £4550 per average practice if fully achieved.

2. Overall Objectives

Patients with severe mental illness (SMI) to have their physical health needs met by increasing early detection and access to evidence-based physical care assessment and

intervention each year. This will improve health outcomes, reduce premature mortality and reduce health inequalities in this cohort.

3. Service scope

There are currently 6100 patients with SMI on GP Mental Health registers in Oxfordshire. At least 60% of patients on the practice Mental Health register to have an annual health check between 1st April 2019 - 31st March 2020.

As some of these patients will be under closer scrutiny of the secondary mental health services, NHSe have estimated that the spread of work between primary care and secondary care should be as follows

- **50%** of people on GP SMI registers in England received a physical health check in a primary care setting.
- **10%** of people on GP SMI registers in England received a physical health check in a secondary care setting.

4. Service delivery

a. Annual Health Check process

GP Practices currently include patients with Serious Mental Illness on their Mental Health Register. This includes patients with a diagnosis of:

- Schizophrenia
- Bipolar
- Psychotic illness
- Those being monitored on Lithium for whatever reason

The SMI register to be used excludes those who are coded as being in remission.

National advice states that clinicians should only consider using the remission codes if the patient has been in remission for at least five years. That is where there is:

- no record of antipsychotic medication,
- no mental health in-patient episodes; and
- no secondary or community care mental health follow-up for at least five years.

Practices should review those labelled currently as in remission, to check they are correctly coded. If they are not truly in remission they will be at higher risk of physical ill-health and should be monitored

This will act as the denominator population and no other exclusions will be counted.
Note this population may include those with LD and a SMI. Each patient in this population register should have access to an annual review.

Sensible organisation of patient call/recall should allow one annual review should be undertaken for the following groups of patients to avoid duplication as long as all appropriate data is collected for payment.

- SMI annual health checks
- Learning disability annual health checks
- Public Health – five yearly NHS health checks (>40 to 74 age groups)

Patients should be offered annual glucose/haemoglobin (HbA1c) and cholesterol (and/or QRISK2 score) (and thyroid stimulating hormone (TSH) and creatinine if on lithium therapy). In addition patients should have their blood pressure (BP), pulse and body mass index (BMI) measured, cancer screening (if appropriate) and a smoking and alcohol status recorded.

The patient should be signposted to healthy lifestyle interventions; e.g. smoking cessation, weight loss support and hypertension, diabetes, hyperlipidaemia (with raised a predicted algorithm for cardiovascular disease (QRISK)) should be actively and appropriately managed. Drug use should also be noted in future years these will need to be recorded and will be part of the monitoring but in the year 2018/2020 this data will not be measured).

b. Detail of an Annual Health Check

Each adult on the Mental Health Register (over the age of 18) to be offered an annual health check that will be recorded on a nationally recommended template (e.g. Bradford Tool)

Each check will include:

- **Body Mass Index (BMI)**
- **Blood Pressure (BP) and pulse***
- **Cholesterol/lipids and or QRISK2**
- **Glucose or Haemoglobin (Hba1C)**
- **Alcohol status**
- **Smoking status**
- Appropriate access to cancer screening; e.g. cervical cancer, breast cancer, bowel cancer
- Medication review

In addition, if the patient is on lithium therapy

- Serum creatinine
- Thyroid stimulating hormone (TSH)

The scope of the collection will be expanded in 2019/20 to collect data on the following. HOWEVER the additional information is captured to support local understanding of service delivery and benchmarking in 2019/20 and will not form part of the core standard measure WHICH REMAINS AS THE 6 KEY MEASURES COLLECTED IN 18/19 (in bold above)

- The delivery of 3 additional elements of the comprehensive physical health check (9 elements in total);
  - An assessment of nutritional status, diet and level of physical activity
  - An assessment of use of illicit substances/non prescribed drugs
  - Medicines reconciliation or review
- The delivery of the corresponding follow-up interventions;
- Access to the relevant national screening programmes.

(Only those in BOLD will be measured for this LCS, QoF also scores cervical screening and blood monitoring of Lithium)

Appropriate interventions should be offered for any abnormalities found e.g.

- Antihypertensive medication.
- Diabetes management
- Smoking cessation
- Weight management
- Statins if a prediction algorithm for cardiovascular disease (QRISK) >10%

Results can be recorded on a standardised SMI template on GP clinical systems, (e.g. Bradford tool @ EMISWeb) which will include all the relevant codes required for each component of the annual health check.

**For reporting of Blood Pressure - CCGs should report on EITHER the number of people who have had both a diastolic AND a systolic blood pressure recording, OR both a diastolic AND a systolic blood pressure recording plus a recording of pulse rate.*

5. Training and data quality checks

Training is embedded within the Bradford screening tool available for practices within EMIS. See also the section on data quality searches that the practice should run within Appendix 2. Emis searches are available to use please following the link.

6. Milestones & timing

At least 60% adult patients on the GP mental health register to have had a structured annual review between 1st April 2019 and 31st March 2020.

7. Monitoring

Data will be extracted from the Emis practice system by SCWCSU around the 1st of the month following the end of each quarter to monitor activity.

Vision practices are requested to submit the necessary evidence for payment in the form of the search output from the clinical system and submit to the SCWCSU by 3rd* of the month following the end of each quarter during the year. (*Deadlines to be confirmed each quarter by SCWCSU).

See APPENDIX 1.

8. Payment

The tariff will be percentage based figure. £30.00 for each comprehensive health check completed capped at 50% of the practice SMI population eg if the population of SMI is 100, then payment will be capped at 50*£30.00. Final payment will made dependent upon the combined yearly total following 31st March 2020. This will supplement the QoF achievement payment.

9. Termination

This service will terminate on 31st March 2020. For termination ahead of this 3 months written notice must be given.

10. Contact

Contact for queries: juliet.long1@nhs.net
Clinical lead: david.chapman-occg@nhs.net

11. References

NICE guidance: Psychosis and schizophrenia in adults: prevention and management
www.nice.org.uk/guidance/cg178

NHSE Publication Feb 2018: Improving physical healthcare for people living with severe mental illness (SMI) in primary care
www.england.nhs.uk/publication/improving-physical-healthcare-for-people-living-with-severe-mental-illness-smi-in-primary-care-guidance-for-ccgs/

www.england.nhs.uk/wp-content/uploads/2018/02/improving-physical-health-care-for-smi-in-primary-care-annexes.pdf

NHSE: The Mental Health Five Year Forward View
www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

Bradford Tool:
https://www.digitalhealth.net/includes/images/news0254/PDF/physical-health-template-casestudy.pdf

Adobe Acrobat Document

(double click icon re Emis template)

Qof guidance 2019/2020
https://www.england.nhs.uk/publication/2019-20-general-medical-services-gms-contract-quality-and-outcomes-framework-qof/

Improving physical healthcare for people living with severe mental illness (SMI) in primary care
https://www.england.nhs.uk/wp-content/uploads/2018/02/improving-physical-health-care-for-smi-in-primary-care.pdf

Severe mental illness (SMI) and physical health inequalities: briefing
https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities

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APPENDIX 1

NHS Oxfordshire CCG

Data Collection Specification for Primary Care Service 2019/20

Data is used by SCWCSU to complete the table below which after OCCG approval is submitted to NHS Digital.

	Number of patients	Percentage of patients receiving check	Time period
The number of people on the General Practice SMI registers (on the last day of the reporting period) excluding patients recorded as 'in remission' (Denominator):			at period end
Of the above, patients who have had (Numerators):			
1. measurement of weight (BMI or BMI + Waist circumference)			in 12 months to period end
2. blood pressure and pulse check (diastolic and systolic blood pressure recording + pulse rate)			
3. blood lipid including cholesterol test (cholesterol measurement or QRISK measurement)			
4. blood glucose test (blood glucose or HbA1c measurement)			
5. assessment of alcohol consumption			
6. assessment of smoking status			
All six physical health checks - note this cannot be greater than the minimum figure reported in 1 to 6 above.			

Note that an individual who has received all six physical health checks should **also** be reported against **each** physical health check, 1 to 6.

The search population for the denominator: The number of people on the GP SMI registers (on the last day of the reporting period) excluding patients recorded as 'in remission' Patients with mental health (MH) diagnosis EXCLUDING in remission OR patients with no diagnosis of MH on lithium medication on the last day of the reporting period is taken as **Patients with mental health (MH) diagnosis EXCLUDING in remission OR patients with no diagnosis of MH on lithium medication on the last day of the reporting period**

All data taken for items 1 – 6 are taken in the 12 months to the period end date

NHS England have published some new technical guidance for 2019-20:
https://www.england.nhs.uk/statistics/statistical-work-areas/serious-mental-illness-smi/

Please use the links at this page for the full technical guidance which includes the Read codes/Snomed codes that are used in the searches used for the extraction.

In all cases, patients who have died or left during the quarter, but who have received a service within the practice will be included. Temporary residents will be included.

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APPENDIX 2

Data Quality and cross checking practice lists with those under the adult mental health

Please use the searches provided by the CSU to help you with data quality checks – these need to be copied from Emis Enterprise into your practice system, they are at: **SCW OCCG Commissioned Services 2019-20/SMI Returns/SMI and LD Register Data Quality searches** (a powerpoint document 'Data Quality SMI and LD searches v2' at the location below talks you through the process).

https://www.oxfordshireccg.nhs.uk/professional-resources/contract-specifications-2019-20.htm

Patients in remission

As part of QoF GPs are meant to check on an annual basis that the patients are correctly coded as being in remission. It should be noted that in remission does not mean not having symptoms currently. Clinicians should only consider using the remission codes if the patient has been in remission for at least five years, that is where there is:

a. no record of antipsychotic medication,
b. no mental health in-patient episodes;
c. and no secondary or community care mental health follow-up for at least five years.

If a patient who has been coded as 'in remission' experiences a relapse then this should be recorded as such in their patient record. In the event that a patient experiences a relapse and is coded as such, they will once again be included in all the associated indicators for schizophrenia, bipolar affective disorder and other psychoses.

Practices can search for those with a SMI code and have currently been coded in remission so that this can be checked for correct coding – See appendix attached for the search

Cross checking practice lists with those under OH Mental health Trust

Once a year the OHMHT should give a list of those patients being seen by the MH trust. Practices can run off a complete list of those with SMI -see appendix attached for the search. This can then be cross checked with the OHMHT list and any differences can be notified. The practice is likely to be looking after a substantial number of patients over and above the OHMT list

The complete denominator list of patients used in the LCS

The denominator patients for use in the SMI (and Lithium monitored) patients used in the Physical health check in SMI LCS can be run off using the searches in the attached appendix.