**NHS Digital**

**Indicator Supporting Documentation**

**IAP00017 People with Serious Mental Illness (SMI) who have received complete list of physical checks**

**Application Form**

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| **Title** | People with Serious Mental Illness (SMI) who have received complete list of physical checks |
| **Set or domain** | CCG OIS 1.12 |
| **Topic area** | Mental Health |
| **Definition** | This indicator provides a CCG- and National-level percentage of patients diagnosed with Serious Mental Illness (SMI) (schizophrenia, bipolar affective disorder and other psychoses) who have received a complete list of physical checks (i.e. record of BMI, blood pressure, ratio of total cholesterol:hdl, blood glucose or HbA1c, alcohol consumption and smoking status.)  This indicator only refers to primary care. If patients with SMI are in long term, institutional care and are not on a GP list, they are excluded from this indicator.  If patients with SMI are in long term, institutional care and are on a GP list, they are counted for this indicator according to their electronic health record at the general practice. This may show they have an SMI, so they are included in the denominator, but will not have the results of tests so are not included in the numerator (even if they have had the tests elsewhere).  This indicator has been developed to measure the effectiveness of the provision of a clinical care component for patients with a specific set of defined mental health problems. The aspect that is being measured is that relating to receiving a complete list of physical checks appropriate to their age and condition. |
| **Indicator owner & contact details** |  |
| **Publication status** |  |
| **Purpose** | This indicator is intended to help inform decisions by CCGs about how best to deploy physical health checks for their SMI populations.  There is a wealth of evidence that those with serious mental illness are generally less healthy than the rest of the population and that poor mental health fosters a decline in physical health. Ensuring those with SMI diagnoses undergo thorough regular physical health checks is essential in ensuring the increased risks of physical health-deterioration are mitigated. |
| **Sponsor** |  |
| **Endorsement** |  |
| **Evidence and Policy base**  Including related national incentives, critical business question, NICE quality standard and set or domain rationale, if appropriate | This indicator is intended to ensure adherence to NICE Clinical Guideline 178 (CG178) recommendation 1.5.3.2 (indicator was previously supporting CG82, rec 1.1.4.1).  Recommendation 1.5.3.2 states: *GPs and other primary healthcare professionals should monitor the physical health of people with psychosis or schizophrenia when responsibility for monitoring is transferred from secondary care, and then at least annually. The health check should be comprehensive, focusing on physical health problems that are common in people with psychosis and schizophrenia. Include all the checks recommended in 1.3.6.1 and refer to relevant NICE guidance on monitoring for cardiovascular disease, diabetes, obesity and respiratory disease. A copy of the results should be sent to the care coordinator and psychiatrist and put in the secondary care notes.*  This indicator also supports some of the goals of NICE Quality Standard 80 (QS80) Quality Statement 6 – Assessing Physical Health. Although this Quality Statement is explicitly supported by CQUIN indicator 1. |
| **Data source** | General Practice Extract Service (GPES) |
| **Justification of source and others considered** | As this indicator is only looking at primary care GPES is the only suitable way to get the needed data |
| **Data availability** | Data from GPES is provided in an aggregate form, so data would be supplied at the granularity requested, in this case CCG and National. |
| **Data quality** | **i) What data quality checks are relevant to this indicator?**  **Coverage**  **Completeness**  **Validity**  **Default**  **Integrity**  **Timeliness**  **Other** |
|  | **If you included ‘Other’ as a data quality check, please describe the check, how it will be measured, and its reason for use below:** |
|  | **ii) What are the current values for the data quality checks selected?** The period of data the current values are calculated from should be stated. Current values should be recorded as a percentage and calculated as described below.  **Period of data:**  **Coverage:**  **Calculation:**  **Completeness:**  **Calculation:**  **Validity:**  **Calculation:**  **Default:**  **Calculation:**  **Integrity:**  **Calculation:**  **Timeliness:**  **Calculation:**  **Other:**  **Calculation:** |
|  | **iii) What are the thresholds for the data quality checks selected?**  **Coverage:**  **Completeness:**  **Validity:**  **Default:**  **Integrity:**  **Timeliness:**  **Other:** |
|  | **iv) What is the rationale for the selection of the data quality checks and thresholds selected above?** |
|  | **v) Describe how you would plan to improve data quality should it not meet, or subsequently fall below, the thresholds required for this indicator.** |
|  | **vi) Who will own the data quality risks and issues for this indicator?**  **Name:**  **Job Title:**  **Role:**  **Email:**  **Telephone:** |
|  | **vii) Describe how the data quality risks and issues will be managed for this indicator, including the escalation process.** |
|  | **viii) Describe any assumptions you have made about data quality for this indicator.** |
|  | **ix) Describe any data quality constraints you are aware of for this indicator.** |
|  | **x) Additional data quality information:** |
| **Quality assurance** |  |
| **Data linkage** |  |
| **Quality of data linkage** |  |
| **Data fields** | The data fields supplied by GPES are as follows. Details of GPES are available from  <http://content.digital.nhs.uk/gpes>.  Practice\_ID – GP practice code  RID – unique count of records associated to a GP practice  AID – unique record identifier for a GP practice  Aggregate Record – includes numbers for the denominator/ numerator and reporting periods |
| **Data filters** | The comprehensive list of criteria applied when selecting records for the numerator and denominator can be found in the appendices of the specification document: <https://indicators.hscic.gov.uk/download/Clinical%20Commissioning%20Group%20Indicators/Specification/CCG_1.12_I00777_S.pdf> |
| **Justifications of inclusions and exclusions**  and how these adhere to standard definitions |  |
| **Data processing** |  |
| **Numerator** | The number of people in the denominator who have a record of a complete list of physical checks appropriate to their age and condition in the preceding 12 months:  • body mass index (BMI),  • blood pressure,  • ratio of total cholesterol:hdl (high-density lipoprotein cholesterol or "good cholesterol.")\* †,  • blood glucose or HbA1c (glycated haemoglobin)\*,  • alcohol consumption and  • smoking status.  \* These two tests are only relevant to people aged 40 or over. Therefore, the complete list of tests refers to only the four relevant tests for people aged under 40  † This test is not relevant for patients aged 40 and over with established CVD. Therefore, the complete list of tests refers to only the other five tests for people aged 40 and over with established CVD |
| **Denominator** | The number of people on the GP list at 31 March with a diagnosis of SMI. Patients identified for this indicator have one or more of the diagnosis codes for schizophrenia, bipolar affective disorder or other psychoses in their electronic health record and their latest mental health diagnosis is not in remission. |
| **Computation** | The indicator value is calculated as the percentage of the denominator that the numerator representes. |
| **Risk adjustment or standardisation type and methodology** | **None**  *Variables and methodology:* |
| **Justification of risk adjustment type and variables**  or why risk adjustment is not used |  |
| **Confidence interval / control limit use and methodology** | Confidence Intervals  *Methodology:*  The formulae for the 100(1 – *α*)% confidence interval limits for the proportion *p* are:  The formulae for the 100(1 – α)% confidence interval limits for the proportion p.  where:  *O* is the observed number of individuals in the sample/population having the specified characteristic (i.e., the numerator);  *n* is the total number of individuals in the sample/population (i.e., the denominator);  *q* = (1 – *p*) is the proportion without the specified characteristic;  *z* is the 100(1 – *α*/2)th percentile value from the Standard Normal distribution. For example for a 95% confidence interval, *α* = 0.05, and *z* = 1.96 (i.e. the 97.5th percentile value from the Standard Normal distribution). |
| **Justification of confidence intervals / control limits used** | Confidence intervals are calculated using the Wilson Score method, as specified in *“Commonly used public health statistics and their confidence intervals” (APHO, March 2008).* |
| **Presentation of indicator** | The indicator values are presented as Excel and CSV files, with column headings: Percentage (indicator value), CI Lower, CI Upper, Denominator, Numerator and Data completeness banding values.  It is presented at National- and CCG-level.  Data is presented for financial years 2013/14 and 2014/15.  Document available on request by email to [indicators@nice.org.uk](mailto:indicators@nice.org.uk) |
| **Contextual information provided alongside indicator**  with justification | This indicator requires careful interpretation and should not be viewed in isolation, but instead be considered alongside information from other indicators and alternative sources such as patient feedback, staff surveys and similar material. When evaluated together, these help to provide a holistic view of CCG outcomes and provide a more complete overview of the impact of the CCGs’ processes on outcomes. |
| **Calculation and data source of contextual information** |  |
| **Use of bandings, benchmarks or targets**  with justification |  |
| **Banding, benchmark or target methodology**  if appropriate |  |
| **Interpretation guidelines** | This indicator requires careful interpretation and should not be viewed in isolation, but instead be considered alongside information from other indicators and alternative sources such as patient feedback, staff surveys and similar material. When evaluated together, these help to provide a holistic view of CCG outcomes and provide a more complete overview of the impact of the CCGs’ processes on outcomes. |
| **Limitations and potential bias** | * This indicator requires careful interpretation and should not be used in isolation. It should be taken in conjunction with other indicators and information from other sources (patient feedback, staff surveys and other such material) that together form a holistic view of CCG outcomes and a fuller overview of how CCG processes are impacting on outcomes. * There is no standardisation for this indicator. Indicator values are presented with 95% confidence intervals recognising the existence of natural variation between the CCG populations. * The indicator only measures care delivered to patients registered with a GP. * A number of factors outside the control of GPs, such as the socio-economic mix of local populations and events in patients’ lives, may determine whether the checks are carried out and may influence rates. * The patterns of providing the physical health checks may vary between practices in terms of: timing and location of tests, whether they are carried out by a GP or nurse, whether they are carried out in a specific clinic, whether all patients could be invited to the clinic or if it is specific to patients with SMI. * There may be local variation in data quality, particularly in terms of coding and recording of results. * Some factors causing or exacerbating SMI are outside the control of the NHS and CCGs. These can vary by region, and may include environmental factors such as air quality, occupational hazards and deprivation.   There may be variation in the prevalence of particular conditions due to differing levels of deprivation, for other geo-demographic reasons or between patients of different ethnic heritages. |
| **Improvement actions** |  |
| **Evidence of variability** | * Evidence of variability can be seen in the embedded spreadsheet. |
| **Similar existing indicators** | Indicators being produced as part of Mental Health QOF:  MH007 - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months  MH003 - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months  While these two indicators are similar, they are only looking at specific health checks and not the full gamut.  Indicators being produced as part of Smoking QOF:  SMOK002 - The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months.  SMOK005 - The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 months.  CCG OIS 1.23 - Smoking rates in people with serious mental illness (SMI) |
| **Coherence and comparability** | This indicator is based on some components that are used in existing Quality and Outcomes Framework (QOF) indicators (i.e. the maintenance of a register of patients with SMI) The list of conditions included in the definition has been reviewed and it is, therefore, considered the most up-to-date and comprehensive list available.  This indicator is made up of elements of other indicators. It shows how many patients with an SMI have received a complete list of six physical checks. The indicator is a percentage, so it should be possible to compare different CCGs and the same CCG in different time periods. |
| **Undesired behaviours and/or gaming** |  |
| **Approach to indicator review** |  |
| **Disclosure control** | This publication is subject to a standard NHS Digital risk assessment prior to issue. Disclosure control is implemented where judged necessary. |
| **Copyright** |  |

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| **IAS Ref Code** | **NICE inherited this indicator and all its supporting documentation from NHS Digital on 1 April 2020** |
| **Indicator Title** |  |
| **Indicator Set** |  |

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| --- | --- | --- | --- |
| Version | Date | Changed By | Summary of changes |
| v.01 | 08/02/13 | Gavin Harrison | Document Created |
| v.02 | 02/06/17 | Andrew Besch | Updated to reflect outcome of IGB meeting of 16/08/2013 |
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**Assurance Summary**

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| **IAS Ref Code** | NICE inherited this indicator and all its supporting documentation from NHS Digital on 1 April 2020 |
| **Indicator Title** |  |
| **Indicator Set** |  |

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| Assurance Stage |  | Date(s) | Comments |
| Application Received |  |  |  |
| Initial Appraisal Completed |  |  |  |
| Peer Review Appraisal |  |  | No peer review currently undertaken |
| Methodology Review Group Discussion |  | 23/08/12 |  |
| Indicator Governance Board Discussion |  | 28/05/13, 16/08/13 |  |
| Signed-off |  | 16/08/13 |  |

Peer Review

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| --- | --- | --- |
| Peer Reviewer(s) / Organisations : | *Outcome of Peer Review consideration:* |  |
|  | 1. **Proposal signed off, with or without caveats** |  |
|  | 1. **Minor changes recommended** |  |
|  | 1. **Declined to sign-off** |  |

Methodology Review Group (MRG)

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| *Outcome of MRG consideration:* |  |
| 1. **No significant issues identified** |  |
| 1. **No significant issues on basis of completion of outstanding actions** |  |
| 1. **Some concerns expressed as caveats or limitations** |  |
| 1. **Significant reservations** |  |
| 1. **Unresolved issues** |  |

Indicator Governance Board (IGB)

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| *Final Appraisal Status* |  |
| 1. **Assured** |  |
| 1. **Assured with Comments** |  |
| 1. **Failed Assurance** |  |

**Peer Review** Summary

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| --- | --- |
| **Indicator Title** |  |
| Indicator Set |  |
| IAS Ref Code: |  |
| Date of Peer Review |  |
| Peer Reviewer(s) / Organisations : | No peer review currently undertaken |
| *Outcome of MRG consideration:* | **Proposal signed off, with or without caveats** |
| Link to Peer Review Appraisal |  |

Indicator Methodology for Consideration - **Methodology Review Group**

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| **Initial Indicator Title** | [Indicator title submitted pre - MRG discussion]  **1.30 People with Serious Mental Illness (SMI) who have received complete list of physical checks** |
| Indicator Set |  |
| IAS Ref Code: |  |
| Introduction | [Give a brief background on which indicators are being considered, especially if they form part of a programme of indicators. Provide any general information such as  •urgency of approval / broad timescales  •history and direction of any indicator programmes involved e.g. General news about NHS Outcomes Framework  •Level of IC’s involvement, e.g. is it commissioned to produce or surface the data ] |

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| Indicator Details - Initial MRG Submission | Date of Initial Discussion: 08/02/13 |
| Rationale / usefulness  Evidence and action ability of indicator [take this directly from the application if possible] | This indicator will support the delivery of healthcare to meet the NICE clinical guideline GC82 on schizophrenia recommendation 1.1.4.1 which says “people with schizophrenia receive a comprehensive multidisciplinary assessment, including a psychiatric, psychological and physical health assessment” |
| Data source | GPES |
| Construction | ***Summary description of the calculation:*** This indicator will be reported annually as a percentage. The indicator will be based upon 12 months of data. |
| Construction | ***Calculation type:*** Percentage |
| Construction | ***Denominator:*** Number of people on the practice list with a diagnosis of SMI (schizophrenia, bipolar affective disorder and other psychoses – see list at end) as defined in appendix 1 of the QOF Mental Health Ruleset v22.0. Patients identified for this indicator have one or more of these diagnosis codes in their electronic health record.  ***Numerator:*** Number of people with a diagnosis of SMI (as above) with a record of BMI, blood pressure, ratio of total cholesterol:hdl, blood glucose or HbA1c, alcohol consumption and smoking status. |
|  | ***Statistical Methods / Risk adjustment variables:*** |
| Construction | ***Other (Quality assurance/interpretation/known limitations):*** |
| Potential Issues  Highlight any of the following that apply  -data source(s) do not collect 100% of events  -data source(s) organisation or geographic coverage shortfalls  -codes or filters not matching the policy question  -data source(s) definitions not meeting policy question  -data source(s) quality problems or inconsistency of reporting  -statistical methods not appropriate for test or audience  -risk adjustment not considered  -long term security of the data source(s)  -timing of data availability for use in indicator  presentation of data likely to mislead or give false confidence in findings | 1. These physical checks are defined in the QOF Mental Health indicators MH11-13, MH19-20 and Smoking 5. However, these are separate and distinct QOF indicators that cannot be used to calculate a proportion of patients receiving all six care processes. 2. Aside from the 12 month timescale, with no exclusions because of a diagnosis late in the year, standard QOF definitions and rules will be used in for this indicator, specifically: 3. Patients in remission from SMI are excluded (see below for definitions). 4. Smoking status to use the QOF definition (see below) 5. The cholesterol:hdl ratio is required only for patients aged 40 and above who do not have established CVD. 6. Blood glucose or HbA1c tests should be performed for people aged over 40 only. 7. These data will only be collectable using GPES. While the data extraction specifications have been rigorously tested as a part of QOF, GPES is not due to deliver data until April 2013. |
| Supporting Documents  Provide links to any additional documentation used to support discussion at MRG | 1. QOF Mental Health Ruleset, v22.0 (appendix 1) 2. QOF Smoking Ruleset v22.0 3. Quality and Outcomes Framework guidance for GMS contract 2012/13 <http://www.nhsemployers.org/Aboutus/Publications/Documents/QOF_2012-13.pdf> 4. Harrison, G., Hopper, K., Craig, T., Laska, E., Siegel, C., Wanderling, J. et al. (2001) Recovery from psychotic illness: A 15- and 25-year international follow-up study. British Journal of Psychiatry, 178:506-517 |

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| Additional Information / Sample Data :  Care processes are defined in the QOD Mental Health indicators as follows.  Alcohol consumption (MH11)  BMI (MH12)  Blood pressure (MH13)  Total cholesterol:hdl ratio (MH19)  Blood glucose or HbA1c (MH20)  Smoking status (Smoking 5)  **Remission from serious mental illness**  Historically, patients have been added to the QOF mental health register for schizophrenia, bipolar affective disorder and other psychoses, but over time it has become apparent that it may be appropriate to exclude some of them from the associated indicators because their illness is in remission.  Making an accurate diagnosis of remission for a patient with a diagnosis of serious mental illness can be challenging and the evidence base to support when to use the ‘remission code’ is largely based on clinical judgment. A recent longitudinal international study of recovery from psychotic illnesses found that as many as 56 per cent of patients recovered from psychotic illnesses to some extent, although only 16 per cent recover if a more stringent concept of recovery is used.  In the absence of strong evidence of what constitutes ‘remission’ from serious mental illness, 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 * with no mental health in-patient episodes; and * no secondary or community care mental health follow-up for at least five years.   Practices may record patients as being in remission. Where a patient is recorded as being ‘in remission’ they remain on the register (in case their condition relapses at a later date) but they are excluded from mental health indicators MH11, MH12, MH13, MH16, MH19 and MH20.  The accuracy of this coding should be reviewed on an annual basis by a clinician. Should a patient who has been coded as ‘in remission’ experience a relapse then this should be recorded as such in their medical record.  In the event that a patient experiences a relapse and is coded as such, they will once again be included in the associated indicators for schizophrenia, bipolar affective disorder and other psychoses. (see Recovery from psychotic illness: A 15- and 25-year international follow-up study. British Journal of Psychiatry, 178:506-517) |

MHREM COD

Codes in remission from serious mental illness

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| Read codes V2 | CTV3 |
| E1005, E1015, E1025  E1035, E1055, E1075  E1106, E1116, E1146  E1156, Eu317, E1166  E1176,  Eu329, Eu32A, Eu26., Eu223 | E1005, E1015, E1025  E1035, E1055, E1075  E1106, E1116, E1146  E1156, Eu317, E1166  E1176,  XaX51, XaX52, XaX53, XaX54 |

Revisions:

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| Revision Date: |  |
| General Comments / Reasoning: |  |
| Revisions: |  |
| Indicator Title |  |
| Data source |  |
| Construction |  |
| Updated Potential Issues |  |

MRG Recommendations, Comments & Updates:

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| --- | --- | --- |
| **Indicator Title** |  |  |
| Indicator Set |  |  |
|  | IAS Ref Code: |  |
|  | Ref code  **Rec 2012/185**  Made: 23/08/12 | More precision around timing and timescales involved would be useful in the description of the numerator and denominator. MRG requested that the indicator state “of the people on the GP list at (e.g. 31 March)” |
|  | Rec Status: | **Resolved / No Action Required** |

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| Ref code  **Rec 2012/186**  Made: 23/08/12 | MRG recommended that the title be rephrased to state explicitly that the indicator relates to primary care, because some people with SMI are not on GP lists (e.g. those in institutions) |
| Rec Status: | **Resolved / No Action Required** |

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| Ref code  **Rec 2012/187**  Made: 23/08/12 | Using a time period of 12 months provides a slight complication in that for people who are diagnosed or relapse in February there won’t be time to do the test by the end of March. Therefore, the implication is that 100% should not be expected as the result of this indicator which needs clarifying in the quality statement. |
| Rec Status: | **Resolved / No Action Required** |

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| Ref code  **Rec 2012/188**  Made: 23/08/12 | MRG commented on the construction of the numerator in which people aged under 40 are not eligible for the full set of physical checks. MRG suggested that either a caveat could be applied to the indicator stating that people are counted as having treatment appropriate to their age, or that under 40’s could be split from those 40 and over in the indicator. |
| Rec Status: | **Resolved / No Action Required** |

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| Ref code  **Rec 2012/189**  Made: 23/08/12 | Indicator approved for escalation to Indicator Governance Board on basis that clarification able to be provided for above recommendations. |
| Rec Status: | **Resolved / No Action Required** |

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| Ref code  **Rec 2012/190**  Made: 23/08/12 | **General Comment on all GPES based indicators**  At present GPES is something of an unknown source with the quality not known until the data is started to be used. MRG commented that there needs to be some measure of quality reflected in the quality statement. MRG recommended a comment about the issue of “deregistered patients” i.e. those who have left but remain on the GP list, and those who have died. This is a general observation about GPES data and the exclusion of patients who have died. |
| Rec Status: | **Resolved / No Action Required** |

Record of Assurance provided by **Indicator Governance Board**

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| **Indicator Title** | **1.12 People with Serious Mental Illness (SMI) who have received complete list of physical checks** |
| Indicator Set |  |
| IAS Ref Code: | IAP00133 |
| Construction Summary | *Denominator:* Number of people on the practice list with a diagnosis of SMI (schizophrenia, bipolar affective disorder and other psychoses) as defined in appendix 1 of the QOF Mental Health Ruleset v22.0. Patients identified for this indicator have one or more of these diagnosis codes in their electronic health record.  *Numerator:* Number of people with a diagnosis of SMI (as above) with a record of BMI, blood pressure, ratio of total cholesterol:hdl, blood glucose or HbA1c, alcohol consumption and smoking status. |

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| Initial IGB discussion | 28/05/13 | Further discussed |  |

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|  | **Strategic Considerations & Implications** |
| Applicant / Sponsor Organisation | NHS England  \*Costing for assurance appraisal included in development cost |
| Assurance process funded? | Yes |
| Indicator rationale | It is expected that CCGs will use this to identify which of the physical checks are not being carried out and which patients this relates to, so that the checks can be carried out and the care for the patient be made appropriate.  The aspect that is being measured is that relating to receiving a complete list of physical checks appropriate to their age and condition. |
| Basis for rationale  [Details of quality statement, policy etc.] | This indicator will support the delivery of healthcare to meet the NICE clinical guideline CG82 on schizophrenia recommendation 1.1.4.1 which says “people with schizophrenia receive a comprehensive multidisciplinary assessment, including a psychiatric, psychological and physical health assessment” |
| Risks & assumptions | * The indicator is reliant on GPES delivery * GPES IAG has given approval for the extract request for this indicator |
| IG Considerations [e.g. release of under-lying data, intermediaries access to data, data ownership impact on production] | *Data Source:* GPES  Access to the underlying data could potentially be sourced from HSCIC who will hold extracted GPES data for a set period or from requests to GPES directly |
| Potential impacts on other business areas [inc outstanding generic issues] | Although this indicator is not seen anywhere else, it is made up of elements of other indicators. This indicator shows how many patients with an SMI, schizophrenia, bipolar affective disorder and other psychoses, have received a complete list of six physical checks. Each of these checks is individually an indicator within the Quality and Outcomes Framework (QOF).  **General Comment on all GPES based indicators**   * At present GPES is something of an unknown source with the quality not known until the data is started to be used. * MRG commented on the issue of “deregistered patients” i.e. those who have left but remain on the GP list, and those who have died. This was a general observation about GP records and a recommendation to further consider the issue of exclusion of patients who have died during the year. * GPES are currently waiting for a response from system suppliers as to whether records of deceased patients could be queried from an archive. |
| Implementation Method  [inc production funding] | NHS England has commissioned HSCIC to produce and disseminate the CCG OIS indicators; this is funded via the Grant In Aid funding to HSCIC.  Collection of the data for the CCG OIS is via existing data collections, in this case the Improving Access to Psychological Therapies dataset. Testing and specification of the indicators is carried out by the Specification Development Service and construction of the indicators is provided by Clinical Indicators via the CI Platform.  Dissemination and presentation of the CCG OIS will be via a number of routes:   * The calculated indicator, numerator and denominator for CCGs will be supplied by messaging to the Calculating Quality Reporting Service (CQRS) for use by CCGs as part of their management information *– this is to be confirmed by NHS England* * The indicators and their underlying data will be made publically available via the HSCIC website. * The data will also be provided to the NHS England for use in their internal Intelligence Tool.   HSCIC expect to produce this indicator as part of the CCG OIS for use by the NHS England from April 2013. |

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|  | **Record of MRG Discussion** |
| Discussion dates: | 23/08/12 |
| By: | Alyson Whitmarsh, Andy Sutherland, Azim Lakhani, Jonathan Hope |
| Summary of MRG discussions: | * More precision around timing and timescales involved would be useful in the description of the numerator and denominator. MRG requested that the indicator metadata state “of the people on the GP list at (e.g. 31 March)” * MRG recommended that documentation be rephrased to state explicitly that the indicator relates to primary care, because some people with SMI are not on GP lists (e.g. those in institutions). The accompanying quality statement has been updated accordingly. * Using a time period of 12 months provides a slight complication in that for people who are diagnosed or relapse in February there won’t be time to do the test by the end of March. Therefore, the implication is that 100% should not be expected as the result of this indicator. This is clarified in the accompanying quality statement. * MRG commented on the construction of the numerator in which people aged under 40 are not eligible for the full set of physical checks. MRG suggested that either a caveat could be applied to the indicator stating that people are counted as having treatment appropriate to their age, or that under 40’s could be split from those 40 and over in the indicator. * The points above have been covered in the Quality Statement produced by the Specification Delivery Service team |
| *Outcome of MRG consideration:* | **Some concerns expressed as caveats or limitations** |
| MRG statement of recommendation: | Indicator approved for escalation to Indicator Governance Board on basis that clarification able to be provided for above recommendations. |
|  | **Additional Assurance Details** |
| Peer Reviewers: | No peer review currently undertaken |
| Peer Review summary: | n/a |
| Range of input  [Have relevant business areas contributed e.g. clinical assurance?] |  |

IGB – Additional Recommendations:

[Add new section as necessary]

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|  | **Recommendations & Updates**  Made: 28/05/13 |
| Comments & Recommendations  [List additional comments and recommendations raised by IGB] | * Clarification sought on whether the MRG suggestion that either a caveat could be applied to the indicator stating that “people are counted as having treatment appropriate to their age”, or that “under 40’s could be split from those 40 and over in the indicator” was followed up, and if so which option was progressed. * Further clarity was also asked for with regards to what the rationale sets out compared to what the indicator is measuring, with further evidence of the discussion around the construct of the numerator had at MRG to be circulated to the board. |
| Action required: | **Further Update IGB** |
| Update:  Made: 07/08/13 | * Discussion held at MRG on 23/8/12 included consideration of the construction of the numerator in which people aged under 40 are not eligible for the full set of physical checks. * The issue was identified to the group with the applicant proposing that standard QOF definitions and rules will be used in for this indicator, specifically:   + Patients in remission from SMI are excluded.   + Smoking status to use the QOF definition.   + The cholesterol:hdl ratio is required only for patients aged 40 and above who do not have established CVD.   + Blood glucose or HbA1c tests should be performed for people aged over 40 only * The suggestion made was that either a caveat could be applied to the indicator stating that people are counted as having treatment appropriate to their age, or that under 40’s could be split from those 40 and over in the indicator. * The quality statement for this indicator has been updated to set out that of the 6 tests, 2 are only relevant to people aged 40 or over (these being ratio of total cholesterol:hdl, and blood glucose or HbA1c). As such “the complete list of tests refers to only the four relevant tests for people under 40, but all six tests for people aged 40 or over. |

Review:

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| Review Timescale | Other |
| Rationale | Issues to consider – Changes to process, policy data source, coding definitions HES definitions ] Indicator recommended for review as GPES comes online |

IGB Sign-off: Indicator Assurance Process Output

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| *Final Appraisal Status* | **Assured with Comments** |
| Basis of Sign-off  [Detail caveats and limitations ] | The board determined that further clarification is required as to why the QOF cut-off was being used. If it is purely financial, which may not be appropriate clinically, this needs to be fed-back to the board, and if there isn’t a clear clinical reason this would need caveating. Alison Roe suggested that further explanation may have already been included within earlier MRG documentation, and this will be checked. The indicator will be signed off as assured with the recommendation to review when GPES data becomes available |
| Sign-off Date | 16/08/2013 |