**NHS Digital**

**Indicator Supporting Documentation**

IAP00330 Smoking rates in people with serious mental illness (SMI)

Indicator and Methodology Assurance Service

**Title: Smoking rates in people with serious mental illness (SMI)**

**Set or domain: CCG OIS 1.23**

**IAS Reference Code: IAP00330**

# Application Form

# Section 1. Introduction / Overview

|  |  |  |
| --- | --- | --- |
|  | **Title** |  |
|  | **Set or domain** | CCG OIS 1.23 |
|  | **Topic area** | Smoking, Mental Health |
|  | **Definition** | The indicator calculates the percentage of people with SMI identified on GP systems who are current smokers.Note that 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).A data period of 12 months is used to produce an annual output; the data is provided by GPES on a pre-determined extraction date following the end of the financial year. |
|  | **Indicator owner & contact details** |  |
|  | **Publication status** | Choose an item. |

Section 2: Rationale

|  |  |
| --- | --- |
| **Purpose** | People with serious mental illness are at increased risk of cardio-vascular disease. It is known that people with SMI are more likely to be smokers than the general population. A sample of GP data (below) suggests that around 40% of people with SMI are smokers, compared to 20% of the general population (General Lifestyle Survey 2010, ONS, reported in Statistics on Smoking - England, 2012, HSCIC).It is not clear whether smoking causes SMI or if SMI causes smoking (or both or neither). There is some evidence that smoking may affect the body to increase vulnerability to some mental health disorders. There is also some indication that smoking may cause an increase in anxiety. Smoking may intensify some of the symptoms of schizophrenia; some research has found that people with schizophrenia who smoke have more positive symptoms than those with schizophrenia who do not smoke.This indicator has been identified as a supporting measure for the delivery of the NHS Outcomes Framework by seeking to reduce premature mortality in adults with serious mental illness (1.5).Smoking is bad for physical and mental health. It is the most important cause of preventable ill health and premature death in the UK. Many people with mental health problems smoke because they find it helps alleviate symptoms, but this effect is short-term. Smoking puts them at even greater risk of physical ill health. It has been reported that deaths from smoking-related diseases are twice as high among people with schizophrenia.People with schizophrenia are three times more likely to smoke than other people and they tend to smoke more heavily. One of the most common explanations of this is that people with schizophrenia use smoking to control or manage some of the symptoms associated with their illness and to reduce some of the side effects of their medication.Although many people with mental health problems say that they smoke to reduce their symptoms, they usually start smoking before their problems begin. Heavy smoking does not necessarily lead to fewer symptoms of mental health problems in the long term. Any short term benefits that smoking seems to have are outweighed by the higher rates of smoking-related physical health problems, such as lung cancer and heart disease, which are common in people with mental health problems.The prevalence of psychotic disorders such as schizophrenia is relatively rare and affects around one in 200 adults each year. As with other mental health problems, however, the prevalence of such disorders is associated with increased social and health inequalities.Smoking increases the breakdown of medicines in the body, so smokers often need to take higher doses to get the same results as someone who does not smoke. Without cigarettes, a lower dosage may be possible, which is likely to reduce the side effects of medicines, such as weight gain, nausea, dizziness, etc. |

|  |  |  |  |
| --- | --- | --- | --- |
|  | **No. patients** | **% patients** |  |
| Patients available in their practice from 1/07/2011 to 30/06/2012 | 869,660 | - |  |
| Patients available in their practice from 1/07/2011 to 30/06/2012 with a diagnosis of SMI anywhere in their record | 6,967 | 0.8 | 2011/12 QOF prevalence of SMI was 0.8%  |
| Patients available in their practice from 1/07/2011 to 30/06/2012 with a diagnosis of SMI anywhere in their record who are current smokers | 2,775 | 39.8 |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CCG** | **Number of Practices** | **Number of patients available in their practice from 1/07/2011 to 30/06/2012 with a diagnosis of SMI anywhere in their record** | **Number of patients available in their practice from 1/07/2011 to 30/06/2012 with a diagnosis of SMI anywhere in their record who are current smokers** | **%** |
| Dummy CCG A | 28 | 1771 | 778 | 43.9 |
| Dummy CCG B | 23 | 1750 | 668 | 38.2 |
| Dummy CCG C | 24 | 1674 | 672 | 40.1 |
| Dummy CCG D | 25 | 1772 | 657 | 37.1 |
| Total | 100 | 6,967 | 2,775 | 39.8 |

These dummy CCGs are based on a sample of 100 practices from the IMS disease analyser database. These practices are spread throughout England and do not form a CCG. The number of practices in the 211 proposed CCGs opening in April 2011 varies from 6 to 127, with an average of 38.4 practices per CCG.

Note that this sample data also looks at all people with SMI including those in remission, who are usually excluded from QOF and, therefore, should be excluded from this indicator. It is estimated that this would make a very small increase to the percentage of current smokers. This would be corrected for the indicator.

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|  | **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 provides support for NICE QS80 Psychosis and schizophrenia in adults Quality Statement 7: Promoting healthy eating, physical activity and smoking cessation which states: Rates of tobacco smoking are also high in people with psychosis or schizophrenia…Offering combined healthy eating and physical activity programmes and help to stop smoking can reduce these rates and improve physical and mental health. |

Section 2 Data

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| **Data source** | 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:**  |

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|  | **Quality assurance** |  |
|  | **Data linkage** |  |
|  | **Quality of data linkage** |  |
|  | **Data fields** |  The data fields supplied by GPES are as follows. Details of GPES are available fromhttp://content.digital.nhs.uk/gpes.Practice\_ID – GP practice codeRID – unique count of records associated to a GP practiceAID – unique record identifier for a GP practiceAggregate 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_1.23_I01974_S.pdf>  |
|  | **Justifications of inclusions and exclusions** and how these adhere to standard definitions |  |
|  | **Data processing** |  |

Construction

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|  | **Numerator** | The number in the denominator who are identified as current smokers. |
|  | **Denominator** | The number of people aged 18 and over 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 is calculated as a percentage. |
|  | **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:*Confidence intervals are calculated using the Wilson Score method, as specified in “Commonly used public health statistics and their confidence intervals” (APHO, March 2008).The formulae for the 100(1 – α)% confidence interval limits for the proportion p are:Formula for calculation of confidence intervals using the Wilson score method 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** |  |

Presentation

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|  | **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 year 2014/15.Data is available on request by emailing indicators@nice.org.uk  |
|  | **Contextual information provided alongside indicator**with justification |  |
|  | **Calculation and data source of contextual information** |  |
|  | **Use of bandings, benchmarks or targets**with justification |  |
|  | **Banding, benchmark or target methodology**if appropriate |  |

**Interpretation**

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| --- | --- | --- |
|  | **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 will 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.
* It may be difficult to isolate changes due to campaigns targeting people suffering SMI, rather than campaigns that target all or other specific groups of smokers.
* 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.
* 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.
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|  | **Improvement actions** |  |
|  | **Evidence of variability** | Evidence of variability can be seen in the embedded indicator release. |

 Risks

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|  | **Similar existing indicators** | 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 1.12 - People with Serious Mental Illness (SMI) who have received complete list of physical checks |
|  | **Coherence and comparability** | This indicator is based on some components that are used in existing Quality and Outcomes Framework (QOF) indicators (the maintenance of a register of patients with SMI) However, it is possible that some people in long term care will not be included in this indicator, for example, those who are not recorded as having SMI on their GP system, or if they don’t have a GP.This indicator looks at all people, regardless of age. While most SMI is likely to be in adults, it is possible that people under 18 could be diagnosed with SMI. If so, their smoking status may not be recorded on the GP system.Despite being part of QOF, it is possible that either the SMI register or smoking status, or both, is not complete or up to date. For example, if patients were identified as having SMI but their smoking status was not recorded or recorded as unknown, then they will be included in the denominator but not in the numerator. |
|  | **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** |  |
| **Indicator Title** | **Smoking rates in people with serious mental NICE inherited this indicator and all its supporting documentation from NHS Digital on 1 April 2020** |
| **Indicator Set** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Version | Date | Changed By | Summary of changes |
| v.01 | 16/07/13 | Geoff Green | Document Created |
| v.02 | 03/07/14 | Michael Cartwright | Updated with sign IGB off |
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**Assurance Summary**

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| --- | --- |
| **IAS Ref Code** |  |
| **Indicator Title** | Smoking rates in people with serious mental NICE inherited this indicator and all its supporting documentation from NHS Digital on 1 April 2020 |
| **Indicator Set** |  |

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| --- | --- | --- | --- |
| Assurance Stage |  | Date(s) | Comments |
| Application Received |[x]  16/07/13 |  |
| Initial Appraisal Completed |[ ]   |  |
| Peer Review Appraisal |[ ]   |  |
| Methodology Review Group Discussion |[x]  18/10/13 |  |
| Indicator Governance Board Discussion |[x]  16/01/2014 |  |
| Signed-off |[x]   |  |

Peer Review

Peer Reviewer(s) / Organisations : None provided

*Outcome of Peer Review consideration:No information provided*

Methodology Review Group (MRG)

*Outcome of MRG consideration:* **No significant issues on basis of completion of outstanding actions**

Indicator Governance Board (IGB)

*Final Appraisal Status* **Assured**

**Peer Review** Summary

Not provided

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

**Initial Indicator Title** Smoking rates in people with serious mental illness (SMI)

Introduction

The CCG OIS is an integral part of NHS England’s systematic approach to quality improvement. It is intended to provide clear, comparative information for CCGs, patients and the public about the quality of health services commissioned by CCGs and the associated health outcomes. All of the CCG outcomes indicators have been chosen on the basis that they contribute to the overarching aims of the five domains in the NHS Outcomes Framework and it is intended as a tool for CCGs to drive local improvement and set priorities. Reference: CCG OIS – NHS England.

This indicator shows the percentage of people who are current smokers out of people with serious mental illness identified on GP systems.

Indicator Details - Initial MRG Submission

Date of Initial Discussion: xx/xx/xx

Rationale / usefulness

Evidence and action ability of indicator [take this directly from the application if possible]

People with serious mental illness are at increased risk of cardio-vascular disease.

It is known that people with SMI are more likely to be smokers than the general population. A sample of GP data (below) suggests that around 40% of people with SMI are smokers, compared to 20% of the general population (General Lifestyle Survey 2010, ONS, reported in Statistics on Smoking - England, 2012, HSCIC).

It is not clear whether smoking causes SMI or if SMI causes smoking (or both or neither). There is some evidence that smoking may affect the body to increase vulnerability to some mental health disorders. There is also some indication that smoking may cause an increase in anxiety. Smoking may intensify some of the symptoms of schizophrenia; some research has found that people with schizophrenia who smoke have more positive symptoms than those with schizophrenia who do not smoke.

This indicator has been identified as a supporting measure for the delivery of the NHS Outcomes Framework by seeking to reduce premature mortality in adults with serious mental illness (1.5).

Smoking is bad for physical and mental health. It is the most important cause of preventable ill health and premature death in the UK. Many people with mental health problems smoke because they find it helps alleviate symptoms, but this effect is short-term. Smoking puts them at even greater risk of physical ill health. It has been reported that deaths from smoking-related diseases are twice as high among people with schizophrenia.

People with schizophrenia are three times more likely to smoke than other people and they tend to smoke more heavily. One of the most common explanations of this is that people with schizophrenia use smoking to control or manage some of the symptoms associated with their illness and to reduce some of the side effects of their medication.

Although many people with mental health problems say that they smoke to reduce their symptoms, they usually start smoking before their problems begin. Heavy smoking does not necessarily lead to fewer symptoms of mental health problems in the long term. Any short term benefits that smoking seems to have are outweighed by the higher rates of smoking-related physical health problems, such as lung cancer and heart disease, which are common in people with mental health problems.

The prevalence of psychotic disorders such as schizophrenia is relatively rare and affects around one in 200 adults each year. As with other mental health problems, however, the prevalence of such disorders is associated with increased social and health inequalities.

Smoking increases the breakdown of medicines in the body, so smokers often need to take higher doses to get the same results as someone who does not smoke. Without cigarettes, a lower dosage may be possible, which is likely to reduce the side effects of medicines, such as weight gain, nausea, dizziness, etc.

Data source: GP data, extracted via GPES.

Construction

 Summary of construction, including the numerator, denominator, statistical method(s), presence of risk adjustment variables (age, sex, casemix etc.), specific codes and filters.

For more complex indicators, summarise here and supply detail in an appendix

***Summary description of the calculation:***

This indicator shows the percentage of people who are current smokers out of people with serious mental illness identified on GP systems.

***Calculation type:*** Percentage

Calculated as a percentage at CCG level.

[ X / Y ] x 100 = Of the number of people SMI identified on GP systems, the percentage who are current smokers.

X = Numerator: of the people in the denominator, the number who are identified as current smokers.

Y= Denominator: the number of people on the GP list at 31 March with a diagnosis of SMI, where it is appropriate for the care component to be carried out. 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.

SMI is defined in the QOF Mental Health Ruleset.

***Statistical Methods / Risk adjustment variables:***

No risk adjustment will be used but Confidence Intervals may be relevant for publication.

***Other (Quality assurance/interpretation/known limitations):***

The data entered onto GP systems can be audited the Local Area Teams of NHS England (previously this was carried out by PCTs). As QOF data attracts payments, it is in the GP’s interest to ensure the data are accurate and complete.

A low rate is desirable. A high rate might indicate a cause for concern.

Any changes to this indicator will be over a long period. It may be difficult to see improvements in the shorter term, particularly as the people in the denominator will be changing.

It may be difficult to isolate changes due to campaigns targeting people suffering SMI, rather than campaigns that target all or other specific groups of smokers.

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| --- | --- |
| Potential IssuesHighlight 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 indicatorpresentation of data likely to mislead or give false confidence in findings | **Risks of perverse incentive and gaming by healthcare providers**None identified.**Data Source: GPES** While sample data has shown that producing this indicator is feasible, its production depends on being able to extract data from all GP practices in England (using GPES) and this has not been done yet.**Completeness**: It is expected that the data will be complete and of a high standard, as its part of QOF. However, it is possible that some people in long term care will not be included in this indicator, for example, those who are not recorded as having SMI on their GP system, or if they don’t have a GP.This indicator looks at all people, regardless of age. While most SMI is likely to be in adults, it is possible that people under 18 could be diagnosed with SMI. If so, their smoking status may not be recorded on the GP system.Despite being part of QOF, it is possible that either the SMI register or smoking status, or both, is not complete or up to date. For example, if patients were identified as having SMI but their smoking status was not recorded or recorded as unknown, then they will be included in the denominator but not in the numerator. |
| Supporting DocumentsProvide links to any additional documentation used to support discussion at MRG | References:Smoking and patients with mental health problems (Health Development Agency, 2004). <http://www.nice.org.uk/niceMedia/documents/smoking_mentalhealth.pdf>Smoking cessation - acute, maternity and mental health services – <http://guidance.nice.org.uk/PHG/51> (expected November 2013).Brief interventions and referral for smoking cessation (PH1) – <http://guidance.nice.org.uk/PH1>Workplace interventions to promote smoking cessation (PH5) – <http://guidance.nice.org.uk/PH5>Smoking cessation - varenicline (TA123) – <http://guidance.nice.org.uk/TA123>Smoking cessation services (PH10) … in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities – <http://guidance.nice.org.uk/PH10>[www.mentalhealth.org.uk](http://www.mentalhealth.org.uk) |
|  |  |

Additional Information / Sample Data :

QOF prevalence of SMI was 0.8% in 2011/12

|  |  |  |
| --- | --- | --- |
|  | **Number of patients** | **Percentage of patients** |
| Patients available in their practice from 1/07/2011 to 30/06/2012 | 869,660 | - |
| Patients available in their practice from 1/07/2011 to 30/06/2012 with a diagnosis of SMI anywhere in their record | 6,967 | 0.8 |
| Patients available in their practice from 1/07/2011 to 30/06/2012 with a diagnosis of SMI anywhere in their record who are current smokers | 2,775 | 39.8 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CCG** | **Number of Practices** | **Number of patients available in their practice from 1/07/2011 to 30/06/2012 with a diagnosis of SMI anywhere in their record** | **Number of patients available in their practice from 1/07/2011 to 30/06/2012 with a diagnosis of SMI anywhere in their record who are current smokers** | **%** |
| Dummy CCG A | 28 | 1771 | 778 | 43.9 |
| Dummy CCG B | 23 | 1750 | 668 | 38.2 |
| Dummy CCG C | 24 | 1674 | 672 | 40.1 |
| Dummy CCG D | 25 | 1772 | 657 | 37.1 |
| Total | 100 | 6,967 | 2,775 | 39.8 |

These dummy CCGs are based on a sample of 100 practices from the IMS disease analyser database. These practices are spread throughout England and do not form a CCG. The number of practices in the 211 proposed CCGs opening in April 2011 varies from 6 to 127, with an average of 38.4 practices per CCG.

Note that this sample data also looks at all people with SMI including those in remission, who are usually excluded from QOF and, therefore, should be excluded from this indicator. It is estimated that this would make a very small increase to the percentage of current smokers. This would be corrected for the indicator.

MRG Recommendations, Comments & Updates:

|  |  |
| --- | --- |
| MRG meeting discussion | Clarification was sought as to the definition of serious mental illness. The applicant confirmed that “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”, and that Serious Mental Illness (SMI) is defined in the QOF Mental Health Rule Set.It was asked as to whether details of the GPES extraction mechanism are available in order to provide clarity around a number of concerns including the potential issue of patients moving practice and duplications, and gaps between smoking and diagnosis – e.g. if someone started smoking then were subsequently diagnosed with SMI, how are they counted?The applicant informed the group that extraction would take the number of people on the GP list with a diagnosis of SMI at 31 March. MRG then questioned if someone is diagnosed 3 months earlier are they counted (when they might have stopped) – the response being yes if GP record is the same.MRG members then asked what about if someone was diagnosed 1 year ago / 2 years etc. In response the applicant updated the group that in line with QOF, anyone with SMI should be assessed every year including their smoking status.Members of MRG noted further potential issues with the source data, highlighting that smokers get asked every year (if they smoke); however, non-smokers don’t get asked again. The question was raised as to what levels of unknown (smoking status) there are? The applicant updated the group that this information wasn’t clear in the test data, although it was known that people with schizophrenia have 3 times the rate. A suggestion was put forward that patient level data available relating to the smoking status of people with diabetes through audit data, and it may be possible to get a feel for individual cohorts and “not knowns” from this.MRG suggested that there may be scope for including rules around expected prevalence by practice, e.g. if prevalence of SMI in a practice falls below a certain threshold, the value might be rejected on the assumption there may be data problems, or that if excessive variation in prevalence of SMI was seen between this would require further consideration. However, it was recognised that this isn’t something that could be done until data becomes available.The applicant noted that this would require practice level data – the proposal put forward is to report at CCG level for use in the CCG Outcome Indicator Set, with no current proposal to (dis)aggregate to GP practice level. However, it was appreciated that there may be at a future point a request to provide information at GP practice level.Members of the group expressed the view that as the data becomes available and starts to be used more issues, and learning, will come out. It was noted that there have been similar issues already discussed in MRG with other indicators based on GPES i.e. that until GPES is up and running and extracting data what is being assured is theoretical.However, it was also stated by the applicant that although it was a new data set, both GP data and the QOF rules were not new. The group discussed whether it would suffice to assure the theoretical construct of the indicator on the basis that potential issues with the extract were highlighted – for instance: Stating (in the quality statement) how double counting might occur it might occur.Making it explicit that there is QOF guidance and it assumed that this is being followed.Clarifying that data isn’t flowing as yet, and that there is the potential for additional issues to be identified when it does become available MRG proposed that further consideration be given to the use of standardisation and its relevance for comparison of CCG’s, the question being asked as to whether comparison would be fair without doing it. Standardisation should be considered by age and sex, with consideration to be given as to whether it would be appropriate to consider conditions/ diagnosis, and possibly deprivation as part of the case mix adjustment.Additionally, further consideration should be given to the use of confidence interval methodologies.MRG sought further clarification on the implications of the indicator following the mental health definition of SMI within the QOF. The register for the mental health clinical area has two parts – one being people with schizophrenia, bipolar affective disorder or other psychoses, the other being people receiving lithium not diagnosed with SMI. The assumption is that the extract will exclude those people being treated with lithium that don’t have SMI but this needs checking with it clearly stated in the supporting documentation what is and isn’t included. Additionally, it was asked whether the appropriateness of including people who have had one-off psychotic episode or were in remission had been considered. The applicant updated the group that people known to be in remission are not included in definition of SMI and that if they were recorded as being in remission they are not counted. This again needs clarifying MRG suggested further consideration be given as to why the indicator covers all ages as there is no requirement to collect smoking status for under 18’s, although QOF (as an incentiviser) is based on 17 up. It was suggested that it might be an option to have the indicator for people aged 18 and over.  |
| Ref code**IAP00330-01**Made: 08/08/13 | Further clarity is required as to the extraction rules with particular reference to how people with an unknown smoking status are either counted or excluded. Examples given were the potential for duplication if patients move practice, gaps between smoking and diagnosis – e.g. if someone started smoking then were subsequently diagnosed with SMI, how are they counted, and how the issue of non-smokers (who are not subsequently re-asked for their smoking status) are treated in the extraction rules. |
| Update:  |  |
| Made: xx/xx/xx |  |
| Existing QOF extraction rules are given below for both mental health and smoking status. | Patients should only be counted once, at their current/most recent practice. There may be gaps between the recording of their smoking status and the recording of an SMI. However, both counts are of the recorded status at the reference date, which is taken aa 1 April each year.The issue of people who have never smoked and ex-smokers are dealt with (separately) within the extraction criteria and the accompanying additional notes.New GMS Contract QOF Implementation: Dataset and Business Rules (v26) – Mental Health Indicator Set – the full ruleset is available at <http://cdn.pcc-cic.org.uk/sites/default/files/articles/attachments/mental_health_ruleset_v26.0_0.pdf>. |

|  |  |
| --- | --- |
|  | This specifies the patient current registration status |
| *Current registration status* | *Qualifying criteria* |
| Currently registered for GMS | Most recent registration date < (REF\_DAT) |
| Previously registered for GMS | Any sequential pairing of registration date and deregistration date where both of the following conditions are met:registration date < (REF\_DAT); andderegistration date >= (REF\_DAT) |

b) Diagnostic code status

 i) Group 1 criteria

|  |  |  |  |
| --- | --- | --- | --- |
| *Code criteria* | *l* |  | *Time criteria* |
|  | Read codes v2 | CTV3 |  |
| *Included* | E10..%, E110.%,E111.%, E1124E1134E114. – E117zE11y.% (excluding E11y2)E11z., E11z0, E11zz, E12..%,E13..% (excluding E135.)E2122, Eu2..%Eu30.% Eu31.%Eu323, Eu328, Eu333Eu32AEu329 | X00S6%(excluding Xa9B0%, E14..%) X00SLX00SM%X00SJ%XSGonE11z., E11z0, E11zzXE1ZZ, XE1ZeXaX54XaX53E130. | *Earliest < (REF\_DAT)* |
|  | *(‘Psychosis, schizophrenia + bipolar affective disease codes)* |  |  |

ii) Group 2 criteria

|  |  |  |  |
| --- | --- | --- | --- |
| *Included* | Read codes v2 | CTV3 | *Latest >= (REF\_DAT – 6/12) AND < REF\_DAT* |
|  | d6...% | d6...% |  |
|  | *(Lithium prescription codes)* |  |  |
| *Excluded* | Read codes v2 | CTV3 | *Latest < (REF\_DAT) AND subsequent to above date* |
|  | 665B. | 665B. |  |
|  | *Code for ‘Stopped lithium’* |  |  |

N.B. Patients meeting any group of criteria to be included

Clinical data extraction criteria are

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| *Field Number* | *Field name* | *Data item* | *Qualifying criteria* |
| 1 | PAT\_ID | Patient ID number | Unconditional |
| 2 | REG\_DAT | Date of patient registration | Latest < (REF\_DAT) |
| 3 | PAT\_AGE | Patients age (years) at REF\_DAT | Unconditional |
| 4 | PAT\_SEX | Patients sex (gender) at REF\_DAT | Unconditional |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 5 | MHEXC\_COD | *Read codes v2* | *CTV3* | Latest < (REF\_DAT) |
|  |  | 9h9..% | XaJ4V% |  |
|  | *(Mental health exception reporting codes)* |  |  |  |
| 6 | MHEXC\_DAT | Date of MHEXC\_COD |  | Chosen record |
|  |  | *Read codes v2* | *CTV3* |  |
| 7 | MH\_COD | E10..%, E110.%, E111.%, E1124E1134E114. – E117zE11y.% (excluding E11y2)E11z., E11z0, E11zz, E12..%,E13..% (excluding E135.)E2122, Eu2..%Eu30.% Eu31.%Eu323, Eu328, Eu333Eu32AEu329 | X00S6%(excluding Xa9B0%, E14..%)X00SLX00SM%X00SJ%XSGonE11z., E11z0, E11zzXE1ZZ, XE1ZeXaX54XaX53E130. | Earliest < (REF\_DAT) |
|  | *(‘Psychosis, schizophrenia + bipolar affective disease codes)* |  |  |  |
| 8 | MH\_DAT | Date of MH\_COD |  | Chosen record |
| 9 | MHP\_COD | *Read codes v2* | *CTV3* | Latest < (REF\_DAT) |
|  |  | 8CY..8CG6.8CS7.8CG628CG608CG618CMG1 | XaIXuXaK8pXaK8sXaK8rXaK8tXaa8pXaa8q |  |
|  |  | (*Code for Mental health care plan*) |  |  |
| 10 | MHP\_DAT | Date of MHP\_COD |  | Chosen record |
| 11 | LIT\_COD | *Read codes v2* | *CTV3* | Latest < (REF\_DAT) |
|  |  | d6...% | d6...% |  |
|  |  | (*Code for Lithium prescription*) |  |  |
| 12 | LIT\_DAT | Date of LIT\_COD |  | Chosen record |
| 13 | ELIT\_COD | *Read codes v2* | *CTV3* | Earliest < (REF\_DAT) |
| 14 | ELIT\_DAT | Date of ELIT\_COD |  | Chosen record |
| 15 | SLIT\_COD | *Read codes v2* | *CTV3* | Latest < (REF\_DAT) |
|  |  | 44W8.%44vE.R1053 | X770u%44W8044W8144W82R1053 |  |
|  |  | *(Code for serum lithium)* |  |  |
| 16 | SLIT\_VAL | Value 1 of SLIT\_COD |  | Chosen record |
| 17 | SLIT\_DAT | Date of SLIT\_COD |  | Chosen record |
| 18 | TLIT\_COD | *Read codes v2* | *CTV3* | Latest < (REF\_DAT) |
|  |  | 44W8044vE. | 44W80 |  |
|  |  | *(Code for serum lithium therapeutic)* |  |  |
| 19 | TLIT\_DAT | Date of TLIT\_COD | Chosen record |  |
| 20 | CRE\_COD | *Read codes v2*44J3.%44JC.44JD.44JF.*(Codes for serum creatinine)* | *CTV3*XE2q5%XaETQ, XaERX44J30, 44J31, 44J3244J33 | Latest < (REF\_DAT) |
| 21 | CRE\_DAT | Date of CRE\_COD | Chosen record |  |
| 22 | TSH\_COD | *Read codes v2*442A.%442K. - 442T.442W.442X.442e. *(Codes for TSH recording)* | *CTV3*XE2wy%442A0442A1 | Latest < (REF\_DAT) |
| 23 | TSH\_DAT | Date of TSH\_COD | Chosen record |  |
| 24 | MH2\_COD | *Read codes v2*E10..%, E110.%, E111.%, E1124E1134E114. – E117zE11y.% (excluding E11y2)E11z., E11z0, E11zz, E12..%,E13..% (excluding E135.)E2122, Eu2..%Eu30.% Eu31.%Eu323, Eu328, Eu333Eu32A, Eu329*(‘Psychosis, schizophrenia + bipolar affective disease codes)* | *CTV3*X00S6%(excluding Xa9B0%, E14..%)X00SLX00SM%X00SJ%XSGonE11z., E11z0, E11zzXE1ZZ, XE1ZeXaX54, XaX53E130. | Latest < (REF\_DAT) |
| 25 | MH2\_DAT | Date of MH2\_COD | Chosen record |  |
| 26 | MHREM\_COD | *Read codes v2*E1005, E1015, E1025 E1035, E1055, E1075 E1106, E1116, E1146 E1156, Eu317, E1166 E1176, Eu329, Eu32A, Eu26., Eu223*(Code for in remission from serious mental illness)* | *CTV3*E1005, E1015, E1025 E1035, E1055, E1075 E1106, E1116, E1146 E1156, Eu317, E1166 E1176, XaX51, XaX52, XaX53, XaX54 | Latest < (REF\_DAT)AND > = MH2\_DAT |
| 27 | MHREM\_DAT | Date of MHREM\_COD | Chosen record |  |
| 28 | MHREM2\_ COD | *Read codes v2*E1005, E1015, E1025 E1035, E1055, E1075 E1106, E1116, E1146 E1156, Eu317, E1166 E1176, Eu329, Eu32A, Eu26., Eu223*(Code for in remission from serious mental illness)* | *CTV3*E1005, E1015, E1025 E1035, E1055, E1075 E1106, E1116, E1146 E1156, Eu317, E1166 E1176, XaX51, XaX52, XaX53, XaX54 | Latest < (REF\_DAT) |
| 29 | MHREM2\_ DAT | Date of MHREM2\_COD | Chosen record |  |
| New GMS Contract QOF Implementation: Dataset and Business Rules (v26) – Smoking Indicator Set – the full ruleset is available at <http://cdn.pcc-cic.org.uk/sites/default/files/articles/attachments/smoking_ruleset_v26.0.pdf> |  |  |  |  |

|  |  |
| --- | --- |
|  | This specified the following patient selection criteria]a) Registration status |
| *Current registration status* | *Qualifying criteria* |
| Currently registered for GMS | Most recent registration date < (REF\_DAT) |
| Previously registered for GMS | Any sequential pairing of registration date and deregistration date where both of the following conditions are met:registration date < (REF\_DAT); andderegistration date >= (REF\_DAT) |
|  | c) Patient population who are aged 15 years and over |
| *Action* | *Qualifying criterion* |
| *Excluded* | Age < 15 yrs at REF\_DAT |

|  |  |  |  |
| --- | --- | --- | --- |
| Clinical data extraction criteria are: |  |  |  |
| *Field Number* | *Field name* | *Data item* | *Qualifying criteria* |
| 1 | PAT\_ID | Patient ID number | Unconditional |
| 2 | REG\_DAT | Date of patient registration | Latest < (REF\_DAT) |
| 3 | PAT\_AGE | Patients age (years) at REF\_DAT | Unconditional |
| 4 | PAT\_SEX | Patients sex (gender) at REF\_DAT | Unconditional |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 30 | SMOK\_COD | *Read codes v2*137.. - 137D.137F. - 137H.137J., 137K., 137M. – 137T.137V.137X. - 137h.137j., 137l.137m.137n.137o. | *CTV3*Ub0oo%(excluding XE0oo, XaIQi%, Ub0oq, 137L., XaQzw, XaXP9, XaXP8, XaXP6, Ub0oo) *(Smoking habit codes)* | Latest < (REF\_DAT) |
| 31 | SMOK\_DAT | Date of SMOK\_COD |  | Chosen record |
| 32 | NSMOK\_COD | *Read codes v2*1371. | *CTV3*XE0oh*(Code for never smoked)* | Most recent of SMOK\_COD< REF\_DAT |
| 33 | NSMOK\_DAT | Date of NSMOK\_COD |  | Chosen record |
| 34 | EXSMOK\_ COD | *Read codes v2*1377. – 137B.137F.137K.137N. – 137O.137S. – 137T.137j., 137l. | *CTV3*Ub1na%(Excluding XaQzw, XaXP8, XaXP6) *(Codes for ex-smoker)* | If LSMOK\_DAT = Null (ALL< REF\_DAT)ORIf LSMOK\_DAT ≠ Null (ALL > LSMOK\_DAT AND < REF\_DAT) |
| 35 | {EXSMOK\_ DAT} | Date of EXSMOK\_COD |  | Chosen array |
| 36 | CSMOK\_COD | *Read codes v2*1372. – 1376.137C. - 137D.137G. - 137H.137J.137M.137P. - 137R.137V.137X. - 137f.137h.137m.137o. | *CTV3*137R.% (excluding XaXP9)XE0og% (excluding XaIuQ)137C.137G.137M.XaIIuXaItgXaJX2(current smoler codes) | Most recent of SMOK\_COD< REF\_DAT |
| 37 | CSMOK\_DAT | Date of CSMOK\_COD | Chosen record |  |
| 38 | EXSMOK1\_ COD | *Read codes v2*1377. – 137B.137F.137K.137N. – 137O.137S. – 137T.137j., 137l. *(Codes for ex-smoker)* | *CTV3* Ub1na%(Excluding XaQzw, XaXP8, XaXP6) | ALL >= (EXSMOK\_ DAT – 24 months)AND< (EXSMOK\_ DAT – 12 months)AND < REF\_DAT |
| 39 | {EXSMOK1\_ DAT} | Date of EXSMOK1\_COD | Chosen array |  |
|  |  | *Read codes v2*1377. – 137B.137F.137K.137N. – 137O.137S. – 137T.137j., 137l. | *CTV3* Ub1na%(Excluding XaQzw, XaXP8, XaXP6)*(Codes for ex-smoker)* | ALL >= (EXSMOK\_ DAT – 36 months)AND< (EXSMOK\_ DAT – 24 months) |
| 40 | EXSMOK2\_ COD |  |  | AND < REF\_DAT |
| 41 | {EXSMOK2\_ DAT} | Date of EXSMOK2\_COD | Chosen array |  |
| 42 | LSMOK\_COD | *Read codes v2*1372. – 1376.137C. - 137D.137G. - 137H.137J.137M.137P. - 137R.137V.137X. - 137f.137h.137m.137o. | *CTV3*137R.% (excluding XaXP9)XE0og% (excluding XaIuQ)137C.137G.137M.XaIIuXaItgXaJX2*(Smoker codes)* | Latest < REF\_DAT |
| 43 | LSMOK\_DAT | Date of LSMOK\_COD | Chosen array |  |
|  |  |  |  |  |
| 45 | SMOKEXC\_ DAT | Date of SMOKEXC\_COD | Chosen array |  |
| 44 | SMOKEXC\_ COD  | *Read codes v2*9hG1.9hG0.137k. | *CTV3*XaLIZXaLIYXaPyn*(Smoking exception reporting codes)* | Latest < REF\_DAT |
| 54 | L3YREXSMOK\_DAT | Latest\_date of a group\_of 3\_yearly consecutive EX SMOK codes | Latest array entry in {EXSMOK\_ DAT}for instance indexwhere{EXSMOK1\_ DAT}index not NullAND{EXSMOK2\_ DAT}indexnot Null |  |
| 52 | LEXSMOK\_ COD | *Read codes v2*1377. – 137B.137F.137K.137N. – 137O.137S. – 137T.137j., 137l. | *CTV3*Ub1na%(Excluding XaQzw, XaXP8, XaXP6)*(Codes for ex-smoker)* | Most recent of SMOK\_COD < REF\_DAT |
|  |  |  |  |  |
|  |  |  |  |  |

Indicator rulesets

1 Indicator SMOK001: The percentage of patients aged 15 or over whose notes record smoking status in the preceding 24 months.

a) Denominator ruleset: To be applied to the patient population aged 15 years and over

|  |  |  |  |
| --- | --- | --- | --- |
| *Rule number* | *Rule* | *Action if true* | *Action if false* |
| 1 | If CSMOK\_DAT >= (REF\_DAT – 24 months)  | Select | Next rule |
| 2 | If PAT\_AGE > 25 AND NSMOK\_DAT ≠ Null AND NSMOK\_DAT > PAT\_DOB +25 years  | Select | Next rule |
| 3 | If PAT\_AGE <= 25 AND NSMOK\_DAT >= REF\_DAT – 24 months)  | Select | Next rule |
| 4 | If LEXSMOK\_COD ≠ Null AND LEXSMOK\_DAT >= (REF\_DAT – 24 months)  | Select | Next rule |
| 5 | If L3YREXSMOK\_DAT ≠ Null AND LSMOK\_DAT = Null OR If L3YREXSMOK\_DAT ≠ Null AND LSMOK\_COD ≠ Null AND L3YREXSMOK\_DAT> LSMOK\_CO  | Select | Next rule |
| 6 | If REG\_DAT >= (REF\_DAT – 3 months)  | Reject | Next rule |
| 7 | If SMOKEXC\_DAT >= (REF\_DAT – 12 months)  | Reject | Select |

b) Numerator ruleset: To be applied to the above denominator population

|  |  |  |  |
| --- | --- | --- | --- |
| *Rule number* | *Rule* | *Action if true* | *Action if false* |
| 1 | If CSMOK\_DAT >= (REF\_DAT – 24 months)  | Select | Next rule |
| 2 | If PAT\_AGE > 25 AND NSMOK\_DAT ≠ Null AND NSMOK\_DAT > PAT\_DOB +25 years  | Select | Next rule |
| 3 | If PAT\_AGE <= 25 AND NSMOK\_DAT >= (REF\_DAT – 24 months)  | Select | Next rule |
| 4 | If LEXSMOK\_COD ≠ Null AND LEXSMOK\_DAT >= (REF\_DAT – 24 months)  | Select | Next rule |
| 5 | If L3YREXSMOK\_DAT ≠ Null AND LSMOK\_DAT = Null OR If L3YREXSMOK\_DAT ≠ Null AND LSMOK\_COD ≠ Null AND L3YREXSMOK\_DAT> LSMOK\_COD  | Select | Next rule |

Additional Notes:

Rule 1: The aim of this rule is to identify any patient whose most recent smoking status is ‘current smoker’ and that it has been recorded in the last 24 months.

True: If the patient has a latest smoking status recorded in the last 24 months of ‘current smoker’, then the patient is to be included in both the numerator and the denominator.

False: If the patient does not have a latest smoking status recorded in the last 24 months of ‘current smoker’, then the patient is further considered.

Rules 2 & 3 are to handle the scenarios for patients who have ‘never smoked’.

Rule 2: The aim of this rule is to identify any patient aged over 25 that has, as the most recent smoking status, a status of ‘never smoked’.

True: If the patient is aged over 25 and has a latest smoking status of ‘never smoked’ which has been recorded after the patient’s 25th birthday, then the patient is to be included in both the numerator and the denominator.

False: If the patient is aged over 25 but does not have a latest smoking status of ‘never smoked’ recorded after the patient’s 25th birthday, then the patient is further considered.

Rule 3: The aim of this rule is to identify any patient aged 25 or under that has, as the most recent smoking status, a status of ‘never smoked’.

True: If the patient is aged 25 or under and has a latest smoking status of ‘never smoked’ which has been recorded in the last 24 months, then the patient is to be included in both the numerator and the denominator.

False: If the patient is aged 25 or under and does not have a latest smoking status of ‘never smoked’ recorded in the last 24 months, then the patient is further considered.

Rules 4 & 5 are to handle the scenarios for patients who are ‘ex-smokers’.

Rule 4: The aim of this rule is to identify any patient that has, as the most recent smoking status, a status of ‘ex-smoker’.

True: If the patient has a latest smoking status of ‘ex-smoker’ which has been recorded in the last 24 months, then the patient is to be included in both the numerator and the denominator.

False: If the patient does not have a latest smoking status of ‘ex-smoker’ recorded in the last 24 months, then the patient is further considered.

Rule 5: The aim of this rule is to identify any patient that has, as the most recent smoking status, a status of ‘ex-smoker’ and has consecutive ‘ex-smoker’ status (i.e. unbroken by a period of a ‘smoking’ status recorded over three consecutive years.

True: If the patient has a latest smoking status of ‘ex-smoker’ and has a smoking status of ‘ex-smoker’ recorded in three consecutive years WITHOUT a later smoking status of ‘smoker’ recorded, then the patient is to be included in both the numerator and the denominator.

False: If the patient has a latest smoking status of ‘ex-smoker’ and does not have a smoking status of ‘ex-smoker’ recorded in three consecutive years WITHOUT a later smoking status of ‘smoker’ recorded, then the patient is further considered.

Where NO smoking status satisfying Rules 3 to 5 above are found, then the patient records should be further examined to see if there are any ‘exceptions’ (Rule 6) that apply before including/excluding the patient in/from the denominator.

Rule 6: The aim of this rule is to identify any patient that ‘recently registered’ at the practice. If the patient has registered at the practice in the last 3 months, the patient should not be included in the denominator, otherwise they are passed on to the next rule.

Rule 7: The aim of this rule is to identify any patient that has a relevant smoking exception code recorded. If this has been recorded in the preceding 12 months, the patient can be excepted and is not included in the denominator

|  |  |
| --- | --- |
| Ref code**IAP00330-02**Made: 08/08/13 | Quality statement to make it explicit that there is QOF guidance and it assumed that this is being followed. Clarification to be provided in the documentation accompanying the indicator regarding QOF definitions and what they mean in terms of inclusions / exclusions for the indicator. This includes as to whether people being treated with lithium that don’t have SMI are included, and confirmation that people in remission are not counted. |
| Update: Made: xx/xx/xx | QOF does not issue guidance about how to manage the care of patients. NICE issue guidelines about the care and management of patients, including for people suffering from schizophrenia and for bipolar affective disorder.Relevant extracts from the QOF business rules are shown above (update to IAP00330-01). This includes relevant inclusions and exclusions of patients. People in remission from SMI are excluded. People being treated with lithium are included – although people are most likely to be being treated with lithium for an SMI. |
| Further Rec: Made: xx/xx/xx |  |
| Update: Made: xx/xx/xx |  |
| Rec Status: | **Further Information Required** [ ]  |
|  | **Resolved / No Action Required** [ ]  |

|  |  |
| --- | --- |
| Ref code**IAP00330-03**Made: 08/08/13 | Standardisation should be considered by age and sex, with consideration to be given as to whether it would be appropriate to consider conditions/ diagnosis, and possibly deprivation as part of the case mix adjustment.Additionally, further consideration should be given to the use of confidence interval methodologies. |
| Update: Made: xx/xx/xx | Smoking prevalence is generally given as a percentage, for example, public health outcomes framework indicator 2.14 Smoking prevalence – adults (over 18s). Standardising the data will mean this CCG OIS indicator will not be comparable with other measures of smoking in the general population.Direct standardisation by age and sex could be included in the production of the indicator. However, it is not seemed to be appropriate to do this given the reasons above.Standardising by diagnosis would be difficult and would be of little benefit. We are unable to say how the diagnoses might be appropriately grouped to give sufficient numbers at CCG level but still be clinically meaningful.Deprivation is not currently available at CCG or practice level, so it would not be possible to standardise for this at present.As this indicator shows a proportion, the Wilson Score method would be appropriate for producing a confidence interval. These are produced as specified in “Commonly used public health statistics and their confidence intervals” (APHO, March 2008).The formulae for the 100(1 – *α*)% confidence interval limits for the proportion p are:$$p\_{lower}=\frac{2O+z^{2}-z\sqrt{\left.z^{2}+4Oq\right.}}{2\left(n+ z^{2}\right)}$$$$p\_{upper}=\frac{2O+z^{2}+z\sqrt{\left.z^{2}+4Oq\right.}}{2\left(n+ z^{2}\right)}$$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 (and *p* is the proportion with 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 percentilevalue from the Standard Normal distribution).This has been applied to the sample data (below). |

Sample Data showing 95% Confidence Interval:

****

|  |  |
| --- | --- |
| Further Rec: Made: xx/xx/xx |  |
| Update: Made: xx/xx/xx |  |
| Rec Status: | **Further Information Required**  |

|  |  |
| --- | --- |
| Ref code**IAP00330-04**Made: 08/08/13 | Further consideration to be given to the indicator covering ages 18 and above rather than all ages |
| Update: Made: xx/xx/xx | The QOF definition for smoking status is based on a patient population who are aged 15 years and over (see update to IAP00330-01, above).We can ask that both the denominator and numerator are limited to people aged 18 years and over when extracted by GPES. |
| Further Rec: Made: xx/xx/xx |  |
| Update: Made: xx/xx/xx |  |
| Rec Status: | **Further Information Required**  |

MRG Recommendations, Comments & Updates:

|  |  |  |  |
| --- | --- | --- | --- |
| **Indicator Title** | Smoking rates in people with serious mental NICE inherited this indicator and all its supporting documentation from NHS Digital on 1 April 2020 | IAS Ref Code: |  |
| Indicator Set |  |  |  |

|  |  |
| --- | --- |
| MRG meeting discussion18/10/13 | The indicator was introduced by explaining the modifications that had been made regarding the recommendations that were made last time the indicator came to MRG. Please see individual indicator record of assurance for details.MRG questioned how the indicator was going to be used and asked if it was going to be compared to current NHS OF indicators for the general population. It had been highlighted that current indicators do not standardise, however as this was a different population, MRG questioned whether it should have been used. It is known that the SMI population is atypical in terms of age and gender. There was debate as to whether it could be compared to general population indicators with these differences in mind. It was decided that if it was used as a comparator over time, no standardisation is appropriate, however how it is currently it could not be compared to the general population indicators and it must be highlighted in the quality statement that it is not standardised.The applicant stated that the data used for the indicator was measuring smoking rates in people over 15 years of age, however as this was a separate data request, it is possible to only include patients over 18 years. Advice was sought by the applicant by MRG as to which was most appropriate. It was agreed that as other indicators measure aged 18+, that this would be the most appropriate. |
| Ref code**IAP00330-01**Made: 18/10/13 | Intended comparisons need to be written in the paperwork. |
| Update: Made: xx/xx/xx |  |
| Ref code**IAP00330-02**Made: 18/10/13 | Indicator to measure only over 18 years and the title should be changed to reflect this. |
| Update: Made: xx/xx/xx |  |
| Rec Status: | **Further Information Required** [ ]  |
|  | **Resolved / No Action Required** [ ]  |

Revisions:

To be completed where changes to the methodology are made by the applicant during the appraisal [i.e. subsequent to the initial application form]

A new section is to be added for each new set of revisions to go to MRG.

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

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| **Indicator Title** | **Smoking rates in people with serious mental NICE inherited this indicator and all its supporting documentation from NHS Digital on 1 April 2020** |
| IAS Ref Code: |  |
| Indicator Set |  |
| Description | This indicator shows the percentage of people who are current smokers out of people with serious mental illness identified on GP systems. |

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| Initial IGB discussion  | 06/12/13 | Further discussed |  |

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| **Strategic Considerations & Implications** |  |
| Applicant / Sponsor Organisation | NHS England |
| Assurance process funded? | **Yes** |
| Indicator rationale | People with serious mental illness are at increased risk of cardio-vascular disease. It is known that people with SMI are more likely to be smokers than the general population. A sample of GP data (see section F-7, below) suggests that around 40% of people with SMI are smokers, compared to 20% of the general population (General Lifestyle Survey 2010, ONS, reported in Statistics on Smoking - England, 2012, HSCIC).It is not clear whether smoking causes SMI or if SMI causes smoking (or both or neither). There is some evidence that smoking may affect the body to increase vulnerability to some mental health disorders. There is also some indication that smoking may cause an increase in anxiety. Smoking may intensify some of the symptoms of schizophrenia; some research has found that people with schizophrenia who smoke have more positive symptoms than those with schizophrenia who do not smoke.Smoking is bad for physical and mental health. It is the most important cause of preventable ill health and premature death in the UK. Many people with mental health problems smoke because they find it helps alleviate symptoms, but this effect is short-term. Smoking puts them at even greater risk of physical ill health. It has been reported that deaths from smoking-related diseases are twice as high among people with schizophrenia.People with schizophrenia are three times more likely to smoke than other people and they tend to smoke more heavily. One of the most common explanations of this is that people with schizophrenia use smoking to control or manage some of the symptoms associated with their illness and to reduce some of the side effects of their medication.Although many people with mental health problems say that they smoke to reduce their symptoms, they usually start smoking before their problems begin. Heavy smoking does not necessarily lead to fewer symptoms of mental health problems in the long term. Any short term benefits that smoking seems to have are outweighed by the higher rates of smoking-related physical health problems, such as lung cancer and heart disease, which are common in people with mental health problems.The prevalence of psychotic disorders such as schizophrenia is relatively rare and affects around one in 200 adults each year. As with other mental health problems, however, the prevalence of such disorders is associated with increased social and health inequalities.Smoking increases the breakdown of medicines in the body, so smokers often need to take higher doses to get the same results as someone who does not smoke. Without cigarettes, a lower dosage may be possible, which is likely to reduce the side effects of medicines, such as weight gain, nausea, dizziness, etc. |
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| Basis for rationale [Details of quality statement, policy etc.] | This indicator has been identified as a supporting measure for the delivery of the NHS Outcomes Framework by seeking to reduce premature mortality in adults with serious mental illness (1.5). |
| Calculation Summary | Calculated as a percentage at CCG level.[ X / Y ] x 100 = Of the number of people SMI identified on GP systems, the percentage who are current smokers.X = Numerator: Of the people in the denominator, the number who are identified as current smokers.Y= Denominator: the number of people on the GP list at 31 March with a diagnosis of SMI, where it is appropriate for the care component to be carried out. 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. |
| Risks & assumptions | While sample data has shown that producing this indicator is feasible, its production depends on being able to extract data from all GP practices in England (using GPES) and this has not been done yet. |
| IG Considerations [e.g. release of under-lying data, intermediaries access to data, data ownership impact on production] | *Data Source:* GP data, extracted via GPES.The underlying data is not publically available; the data will be extracted by GPES for calculation of the indicator. GPES is a primary care data extraction service managed centrally by the HSCIC. |
| Potential impacts on other business areas [inc outstanding generic issues] |  |
| 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 as part of the Quality and Outcomes Framework (QOF). 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 indicators and their underlying data will be made publically available via the HSCIC website and the Indicator Portal. • The data will also be provided to NHS England for use in their internal Intelligence Tool.Subject to confirmation by NHS England, 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. |

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| **Record of MRG Discussion** |  |
| Discussion dates: | 18/10/13 |
| By: |  |

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| Heather Dawe | HSCIC | Programme Manager, Clinical Indicators |
| Paul Fryers | PHE | Deputy Director, East Midlands Knowledge and Intelligence Team |
| Alyson Whitmarsh | HSCIC | Programme Manager, Clinical Audit |
| Chris Dew | HSCIC | Section Head, Clinical Indicators |
| Andy Sutherland | HSCIC | Statistics Head of Profession |
| Paul Iggulden | HSCIC | Interim Head of Clinical Analysis, Research & Development |
| Simone Chung | HSCIC | Principal Information Analyst, Clinical Indicators |

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| Summary of MRG discussions: | **Summary of MRG discussion** - 08/08/13* Clarification was sought as to the definition of serious mental illness. The applicant confirmed that “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”, and that Serious Mental Illness (SMI) is defined in the QOF Mental Health Rule Set.
* It was asked as to whether details of the GPES extraction mechanism are available in order to provide clarity around a number of concerns including the potential issue of patients moving practice and duplications, and gaps between smoking and diagnosis.
* MRG suggested that there may be scope for including rules around expected prevalence by practice, e.g. if prevalence of SMI in a practice falls below a certain threshold, the value might be rejected on the assumption there may be data problems, or that if excessive variation in prevalence of SMI was seen between this would require further consideration. However, it was recognised that this isn’t something that could be done until data becomes available.
* The proposal put forward is to report at CCG level for use in the CCG Outcome Indicator Set, with no current proposal to (dis)aggregate to GP practice level. However, it was appreciated that there may be at a future point a request to provide information at GP practice level.
* Until GPES is up and running and extracting data, what is being assured is theoretical. However, it was also stated by the applicant that although it was a new data set, both GP data and the QOF rules were not new.
* The group discussed whether it would suffice to assure the theoretical construct of the indicator on the basis that potential issues with the extract were highlighted – for instance:
	+ Stating (in the quality statement) how double counting might occur it might occur.
	+ Making it explicit that there is QOF guidance and it assumed that this is being followed.
	+ Clarifying that data isn’t flowing as yet, and that there is the potential for additional issues to be identified when it does become available
* MRG proposed that further consideration be given to the use of standardisation and its relevance for comparison of CCG’s, the question being asked as to whether comparison would be fair without doing it. Standardisation should be considered by age and sex, with consideration to be given as to whether it would be appropriate to consider conditions/ diagnosis, and possibly deprivation as part of the case mix adjustment. Additionally, further consideration should be given to the use of confidence interval methodologies.
* The register for the mental health clinical area has two parts – one being people with schizophrenia, bipolar affective disorder or other psychoses, the other being people receiving lithium not diagnosed with SMI. The assumption is that the extract will exclude those people being treated with lithium that don’t have SMI but this needs checking with it clearly stated in the supporting documentation what is and isn’t included.
* Additionally, it was asked whether the appropriateness of including people who have had one-off psychotic episode or were in remission had been considered. The applicant updated the group that people known to be in remission are not included in definition of SMI and that if they were recorded as being in remission they are not counted.
* MRG suggested further consideration be given as to why the indicator covers all ages as there is no requirement to collect smoking status for under 18’s, although QOF (as an incentiviser) is based on 17 up. It was suggested that it might be an option to have the indicator for people aged 18 and over.

**Post-MRG updates:*** Update on QOF extraction rules: Patients should only be counted once, at their current/most recent practice. There may be gaps between the recording of their smoking status and the recording of an SMI. However, both counts are of the recorded status at the reference date, which is taken aa 1 April each year. People in remission from SMI are excluded. People being treated with lithium are included – although people are most likely to be being treated with lithium for an SMI.
* Smoking prevalence is generally given as a percentage, for example, public health outcomes framework indicator 2.14 Smoking prevalence – adults (over 18s). Standardising the data will mean this CCG OIS indicator will not be comparable with other measures of smoking in the general population. Direct standardisation by age and sex could be included in the production of the indicator. However, it is not seemed to be appropriate to do this given the reasons above.
* Standardising by diagnosis would be difficult and would be of little benefit. We are unable to say how the diagnoses might be appropriately grouped to give sufficient numbers at CCG level but still be clinically meaningful.
* Deprivation is not currently available at CCG or practice level, so it would not be possible to standardise for this at present.

**Summary of MRG discussion – 18/10/13*** MRG questioned how the indicator was going to be used and asked if it was going to be compared to current NHS OF indicators for the general population. It had been highlighted that current indicators do not standardise, however as this was a different population, MRG questioned whether it should have been used. It is known that the SMI population is atypical in terms of age and gender. There was debate as to whether it could be compared to general population indicators with these differences in mind. It was decided that if it was used as a comparator over time, no standardisation is appropriate, however how it is currently it could not be compared to the general population indicators and it must be highlighted in the quality statement that it is not standardised.
* The applicant stated that the data used for the indicator was measuring smoking rates in people over 15 years of age, however only the data for over 18 could be used. It was agreed that as other indicators measure aged 18+, that this would be the most appropriate. The title should reflect this.

**Post-MRG revisions:** |
| *Outcome of MRG consideration:* | **No significant issues on basis of completion of outstanding actions** |
| MRG statement of recommendation: |  |
| **Additional Assurance Details** |  |
| Peer Reviewers |  |
| Peer Review summary: |  |
| Range of input[Have relevant business areas contributed e.g. clinical assurance?] | The conditions are already defined in the QOF business rules, which had clinical input in their development. |

IGB – Additional Recommendations:

[Add new section as necessary]

**Recommendations & Updates**

Made: 16/01/14

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| Comments & Recommendations[List additional comments and recommendations raised by IGB] | The Board recommended that the indicator be assured on condition that the following chairs actions are met: a. Clarification be provided as to how smokers are described and whether the selection of read codes etc. is based on any standard approach.b. Further evidence be provided for the justification not to standardise.c. That the indicator quality statement reflects that data quality is unknown until GPES is launchedIn anticipation of the satisfactory completion of these actions the indicator is put forward for review in one year on the basis that issues relating to data quality should be explored as GPES comes online. |

Action required: **Further Update IGB** [x]

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| Update:Made: xx/xx/xx | 1. As stated in our application to MRG (although not included in the IGB papers), we are using the same Read codes as are used in QOF, this means that we are using a standard approach and not creating a different definition of smoking status to that which is already used and widely understood. The Read codes used will be maintained in line with the QOF to ensure this consistency of definition is maintained.
2. As stated in our application to MRG, our decision not to standardise the indicator was based on the fact that other smoking indicators published by HSCIC and in the Public Health Outcomes Framework are not standardised; we felt it was important to be consistent with other indicators on this topic and MRG accepted this position. Until the coverage and completeness of the GPES data extract is known, we are unable to review the volumes to determine whether standardisation would be possible; we may be unable to directly standardise the indicator if there are small numbers and we know that MRG and IGB would be unlikely to support the suggestion of indirect standardisation for the CCGOIS. The best option at the present time, therefore, is to leave the indicator un-standardised. We would be willing to investigate the options for standardisation in future years when we have received data via GPES.
3. The following sentence has been added into the draft IQS .

“It should be noted that the completeness and quality of the data to be used in the indicator calculation remains unknown until the GP Extraction Service is live.”  |

Review:

Review- 3 years

IGB Sign-off:

*Final Appraisal Status* **Assured**

Basis of Sign-off [Detail caveats and limitations ]

The Board recommended that the indicator be assured on condition that the following chairs actions are met:

* Clarification be provided as to how smokers are described and whether the selection of read codes etc. is based on any standard approach.
* Further evidence be provided for the justification not to standardise.
* That the indicator quality statement reflects that data quality is unknown until GPES is launched.

In anticipation of the satisfactory completion of these actions the indicator is put forward for review in one year on the basis that issues relating to data quality should be explored as GPES comes online.

Sign-off Date: 11/04/14