CONFIDENTIAL

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

INDICATOR DEVELOPMENT PROGRAMME

Consultation report on indicator(s)

Indicator area: Severe mental illness (SMI)

Consultation period: 26 January 2015 – 23 February 2015

Potential output: Recommendations for the NICE Menu for the Quality and Outcomes Framework (QOF)

Contents

Indicator included in the consultation 2
Summary of consultation responses 2
Comments by indicator (IND-1) 2
Considerations for the Advisory Committee 4
Appendix A: Consultation comments 5
Appendix B: Equality impact assessment for IND 1 (severe mental illness) .. 25

CONFIDENTIAL

Indicator included in the consultation

ID	Indicator	Evidence source
IND-1	The percentage of patients aged between 25 and 84 years with schizophrenia, bipolar affective disorder and other psychoses who have had a CVD risk assessment performed in the preceding 12 months.	Recommendations 1.1.3.1, 1.1.3.6, 1.1.3.7, 1.3.3.4, 1.3.6.5, 1.5.3.1, 1.5.3.2 and 1.5.3.3 from the NICE guideline on psychosis and schizophrenia and 1.2.11, 1.2.12, 1.2.13, 1.2.14 and 1.10.14 from the NICE guideline on bipolar disorder and 1.1.8 from the NICE guideline on lipid modification.

Summary of consultation responses

Mixed comments were received from stakeholders on this indicator. Some stakeholders including the Royal College of Psychiatrists highlighted their support for this indicator. However stakeholders commented that this indicator alone would not improve the cardiovascular health of people with severe mental illness (SMI).

It was suggested a more useful indicator may be one supporting physical health in patients with severe mental health problems, through an agreed action plan.

Comments by indicator (IND-1)

> *The percentage of patients aged between 25 and 84 years with schizophrenia, bipolar affective disorder and other psychoses who have had a CVD risk assessment performed in the preceding 12 months.*

It was suggested this should be a secondary care indicator as people could then have blood tests and advice together as part of regular reviews.

A number of comments were received about the timeframe of 12 months being too frequent. Stakeholder highlighted high rates of non- attendance at general practice appointments for people with SMI, it was suggested that further tests may result in more people not attending appointments.

Stakeholders felt the lower age limit of 25 years was not appropriate for annual assessment, some suggested 25 was too low, with others suggesting is was too high.

CONFIDENTIAL

Stakeholders commented that, although it is important that this group receives lifestyle advice and support, a majority of people with SMI will have 10 year risks well below the intervention levels. The age of 25 is the lower validated age limit for the QRISK2 tool. This was raised by stakeholders who commented on the importance of outlining which risk assessment tool should be used for this indicator. It was highlighted some tools have a minimum age limit above 25 so would not be suitable with the current indicator wording. It was suggested the indicator should outline a specific tool or tools e.g. QRISK2 appropriate for this indicator.

Stakeholders were asked during consultation how primary care currently deals with the specific needs of people with SMI in relation to smoking cessation:

- Stakeholders including the Royal College of Psychiatrists and Mind highlighted evidence that suggests people with a mental illness are less likely to be offered smoking cessation services than the general public even though they may be as motivated to stop smoking.
- There were mixed comments from stakeholders over who should be responsible for smoking cessation support and treatment for people with SMI. Some felt this should be the responsibility of primary care whilst others thought community care was the more appropriate setting for this.
- Action on Smoking and Health (ASH) commented GPs may be unaware of the best ways of supporting smokers with severe mental health problems and the cessation treatments available. They felt this highlights a training need for GPs and a gap in service provision for people with SMI who wish to access smoking cessation services.

Stakeholders were also asked at consultation how primary care currently addresses weight management in people with SMI:

- Stakeholders commented that, although the care and treatment course of people with schizophrenia and psychosis varies considerably, antipsychotic medication remains the primary treatment in most cases. They highlighted this treatment can often have side effects, including weight gain making this an important consideration for people with SMI.
- A CCG commented that people with SMI should have access to weight management schemes through referral from GP practices.

- Some stakeholders highlighted evidence to suggest primary care currently does not address weight management systematically for people with a SMI. They also felt healthcare staff other than GPs e.g. practice nurses could potentially play a valuable role in ensuring weight management support is provided for people with SMI.

Considerations for the Advisory Committee

The specific issues that the Advisory Committee is asked to consider when making recommendations on which indicators should be published on the NICE menu for the QOF are stated below.

These issues are also addressed in the indicator development reports which will include suggestions for possible amendments to how the indicators should be specified following piloting and public consultation.

The Advisory Committee is asked to consider:

- is this indicator more appropriate for secondary care?
- what timeframe should apply to this indicator?
- is a lower age limit of 25 years appropriate for this indicator?
- should a specific CVD risk assessment tool (e.g. QRISK2) be included in the indicator wording?
- should the indicator include people with a diagnosis of cardiovascular disease?

The Committee is asked to note that on day 2 a discussion will be held regarding physical health for people with SMI, this session will include smoking cessation and weight management.

CONFIDENTIAL

Appendix A: Consultation comments

Indicator ID.	Stakeholder Organisation	Comment
IND 1	South East Staffordshire & Seisdon Peninsular CCG	This indicator does add some specific requirements to the lifestyle check, but ideally I'd like to see some sort of action plan to support physical health in patients with severe mental health problems.
IND 1	Pennine Surgery	This is the hardest group of patients to engage with. If the patient is under the care of the hospital there are some patients that will not come to see a GP or practice nurse for an annual review. The previous years attempts at collecting this information via glucose and cholesterol did not provide the practice is any high risk patients that needed adding to the primary prevention register. This should be done in Secondary care as they do take their bloods and they can offer them the advise as part of their regular reviews.
IND 1	County Durham and Darlington Local Medical Committee	There is no additional advantage in carrying out a CVD risk assessment more frequently than every 36 months. The lower age limit for this indicator should be reconsidered and perhaps increased to 40. There is no evidence that calculating CVD risks for patients under 40, even with severe mental illness carries any significant benefit. Recording smoking status with smoking cessation advice and support if appropriate and recording weekly alcohol consumption with advice about alcohol if appropriate might be more helpful. However this need not be done face-to-face nor should nor need there be a requirement for this to be carried out by a GP.
IND 1	Whitehall Surgery	The indicator does not take into consideration that patients can be on remission for years, and having to see them to assess risk every year when no active mental illness is present will put too much unnecessary pressure on practice. I consider it should add for patients who has been prescribed any antidepressant, antipsychotic or mood stabiliser, and to do over the last 24 months or similar, as risk will not change so much in a 12 month period.

CONFIDENTIAL

Indicator ID.	Stakeholder Organisation	Comment
IND 1	South Cheshire and Vale Royal CCG's	Primary care should already be trying to tackle smoking and obesity in this group of patients, as highlighted from physical health check indicators. Adding this into QOF may make monitoring more robust, but it is notoriously difficult to get this group of patients to attend for monitoring. This will impact on the success of the QOF indicator.
IND 1	The Royal College of Psychiatrists - Faculty of Child and Adolescent Psychiatry	In relation to question 3 ("Do you think there is potential for differential impact (in respect of age, disability and gender reassignment, pregnancy [...]) [...]", we would suggest that having the QOF confined to 25-84 year olds is unwise. The QOF should have no lower age limit. There is ample evidence that young people under 25 develop schizophrenia. There is also ample evidence that their physical health does not get attended to as regularly as it might. There are also many studies that underpin the practice of getting younger people involved in healthcare practices that stand them in good stead for life. As such, having an artificial divide between under- and over-25s will lead to young people with schizophrenia being overlooked by GPs in terms of CV risk factor screening and will also lead young people into the belief that they do not need to engage with this aspect of their healthcare.

CONFIDENTIAL

Indicator ID.	Stakeholder Organisation	Comment
IND 1	NHS England and NHS Employers	It is felt that this indicator may potentially have a low impact particularly as practices GPs have little input into this cohort of patients. There are concerns around the implementation of this indicator being disease specific. Has a bundled CVD indicator been considered? This cohort of patients already have an annual review (MH002) and CVD risk assessment could be built into the template for the review. This would provide an opportunity for primary prevention at an earlier stage and remind GPs of their higher risk. Smoking cessation is particularly difficult in this group and it is not clear if practices offer anything in addition to core cessation services but the familiarity of the staff at the practice would help support this group. Weight management is also a problem and sometimes is not prioritised as the mental health issues dominate. The updated clinical guideline for lipid modification recommends the use of QRISK2 as the only tool for CVD risk assessment (a change which we are aware will impact the current CVD-PP indicator), would that be the only tool suitable for use for this indicator also?
IND 1	Heart UK	Do stakeholders think this indicator is more or less likely to improve cardiovascular health in people with severe mental illness compared with the physical health check indicators currently included on the NICE menu of indicators? The current NICE menu of indicators includes an indicator on the percentage of patients aged 40 and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol: hdl ratio in the preceding 15 months. With elevated cholesterol being a major risk factor for CVD, HEART UK would like to see a standalone indicator on cholesterol in this way. The charity regrets that a similar such indicator was withdrawn from the QOF last year: MH004 (the percentage of patients aged 40 or over with schizophrenia, bipolar, affective disorder or psychoses who have a record of total cholesterol in the proceeding 12 months). While we welcome incentives for CVD risk assessment, HEART UK would prefer an individual indicator on cholesterol as well/instead to make sure cholesterol measurement and

CONFIDENTIAL

Indicator ID.	Stakeholder Organisation	Comment
		management are sufficiently prioritised. How does primary care currently deal with the specific needs of people with severe mental illness in relation to smoking cessation? • How does primary care currently address weight management in people with severe mental illness? • Do stakeholders consider there to be any specific areas of care which should be an explicit requirement of care planning in primary care for all people with severe mental illness?
IND 1	East and North Hertfordshire CCG	The CCG would question the age range of 25-84, some CAMHS services stop seeing young people after their 16th birthday, others will support young people until they are 18. This could mean those aged 16-25 are not picked up as being at high risk of CVD and not receive early intervention.
IND 1	East and North Hertfordshire CCG	Do stakeholders think this indicator is more or less likely to improve cardiovascular health in people with severe mental illness compared with the physical health check indicators currently included on the NICE menu of indicators? We would require a definition of CVD health checks and how this is different from NHS Health Checks or physical health checks. Would this more appropriate if this was linked with NHS Health Checks?
IND 1	East and North Hertfordshire CCG	- How does primary care currently address weight management in people with severe mental illness? Similar to general population and will have access to weight management schemes through referral from GP practices. Also physical health and exercise forum is considering including PE in MH patients as a specialist area for commissioning.

CONFIDENTIAL

Indicator ID.	**Stakeholder Organisation**	**Comment**
IND 1	East and North Hertfordshire CCG	Do stakeholders consider there to be any specific areas of care which should be an explicit requirement of care planning in primary care for all people with severe mental illness? The QOF indicator should include CVD/physical health assessment of all MH patients not just severe MH. NHS Health Checks and physical health checks should become part of care planning.
IND 1	British Heart Foundation	We agree. However, some risk assessment algorithms do not provide an quantitative assessment of CVD risk at younger ages, so assessment of attainment will need to define 'CVD risk assessment' in patients under the age of 40. This could be addressed by explicitly requiring a risk assessment using an appropriate algorithm, such as Q Risk 2 as in QOF indicator 8. Support in implementation of this indicator is available from the BHF – we provide a booklet that helps mental health service users take small steps towards a lifestyle that's good for your heart and is full of useful facts, practical tips and advice. This is available at: https://www.bhf.org.uk/publications/healthy-eating/everyday-triumphs-g972 The concept that intervention in primary care should be based on a ten risk assessment and threshold for intervention, is based on NICE evidence review. We recommend NICE considers reviewing the evidence supporting the use of life time risk assessment as a CVD risk assessment approach (see the Joint British Societies Consensus recommendations for the prevention of cardiovascular disease (JBS3). This is available at: http://heart.bmj.com/content/100/Suppl_2/ii1.short?g=w_heart_top10_tab)"
IND 1	Diabetes UK	We support the aim of this indicator to reduce the physical health inequalities faced by people with SMI. However, it is not clear whether the CVD risk assessment includes diabetes. It is very important that diabetes is included, as it is a major risk factor for developing CVD. We know that people with severe mental illness have raised rates of modifiable CVD risk factors, including diabetes. Around 10-15 per cent of those on antipsychotic medication develop Type 2 diabetes. This is a rate 2 to 3 times higher than the general population.

CONFIDENTIAL

Indicator ID.	Stakeholder Organisation	Comment
		The cardiovascular health of people with severe mental illness will not be improved by screening alone. Identification of people is an important first step. If people are then found to have, or be at high risk of diabetes they need to be offered intensive lifestyle interventions as recommended by NICE. It is equally important that high-quality prescribing is a prerequisite from the start of treatment. This means that results need to be recorded and well communicated, particularly between services. Identification of people at high risk of Type 2 diabetes amongst people with SMI, should follow the recommendations – noted below – in PH38.
IND 1	Individual- Retired GP and carer	These two studies set the context for why it is important to encourage greater primary care involvement in aspects of physical healthcare if the current health inequalities of this vulnerable population are to be addressed. I wanted to first frame my specific responses to your consultation with two recent large primary care database studies: Reilly at al (2012), examining the records of 1,150 people with severe mental illness (schizophrenia - 56%; bipolar disorder - 37%) from 64 practices in England. • Over the previous 12 months, approximately two thirds of patients were seen by a combination of primary and specialist services and one third were seen only in primary care. • This study also revealed a marked reduction in annual GP consultation rate for this population, averaging only 3 (range 2–6). This is much lower than the annual rates of 13 to 14 reported in the mid-1990s (Nazareth and King, 1992) and only slightly higher than the annual consultation rate for the general population of 2.8 (range 2.5–3.2) in 2008 (Hippisley-Cox and Vinograova, 2009). • Moreover practice nurses, who are key providers of cardiovascular risk screening and health education, saw this population on average only once a year compared with the general practice population rate of 1.8 times per year. The authors concluded that practice nurses are an under-utilised resource for this population. Smith et al (2013). Another relevant primary care study of 314 general practices in Scotland, compared the nature and extent of physical health comorbidities between 9,677 people with psychosis and schizophrenia and 1,414,701 controls (Based on the presence of a possible recorded diagnosis for 32 index physical

CONFIDENTIAL

Indicator ID.	Stakeholder Organisation	Comment
		conditions, the study found that people with schizophrenia were more likely to experience multiple physical comorbidities. Lower than expected rates of CVD led the authors to conclude there was a systematic under-recognition and under-treatment of CVD in people with schizophrenia in primary care.
IND 1	Individual- Retired GP and carer	First consultation question More or less likely to improve CV health? In my view this proposed indicator is more likely to improve CV health of this vulnerable population than the current indicators. Lowering the threshold age range for CVD risk assessment to 25 better reflects the clinical situation where CVD risk often establishes itself at the time of onset of psychosis, and therefore at a much earlier age than CVD risk does for the general population. E.g. • Onset of psychosis occurs for the majority in late adolescence and early adulthood (Kirkbride et al.,2006); similarly peak age of onset for those with bipolar disorder is young - typically15-19 yrs. • Moreover commencement of antipsychotic medication (primary treatment recommendation for psychosis and schizophrenia eg NICE CG 178, and in mania associated with bipolar disorder e.g NICE CG 185) is associated with rapid and sometimes aggressive acceleration of CVD risk within as little as 8 weeks from treatment initiation (Correll et al 2014; Foley et al 2011). Thus the proposed indicator will appropriately remove the limitations posed by the current age 40 yrs threshold for estimating glucose/HbA1c (NM 18) and cholesterol (NM 42) when it is evident that cardiometabolic risk accelerates rapidly for a group in their 20s and 30s, at ages primary care would not normally consider for active primary or secondary CVD prevention, and yet who are at high risk of dying young. The choice of Q Risk 2 itself may have some limitations, recently evaluated by Osborn et al as part of the Primrose study (Osborn et al 2014). However Q Risk 2 still performed acceptably and has the major advantage of being a risk calculator that primary care is familiar with. An important consideration in introducing a new indicator is its implementation in real-world settings. Hardy S et al. (Hardy & Gray, 2012) found that by writing to offer a pre-arranged appointment to patients

CONFIDENTIAL

Indicator ID.	Stakeholder Organisation	Comment
		with severe mental illness to attend their GP for an annual physical health review could achieve 70% attendance rates. The effectiveness of this approach may also have been linked to the QOF incentive system prior to its alteration last April. Encouragingly Yeomans et al, 2014 evaluated the introduction of a computer-based physical health screening template for use with primary care information systems across Bradford based on standards recommended by NICE CG 178 for physical health and cardiovascular risk screening. The screening template was taken up by 75% of GP practices and was associated with better quality screening than usual care, doubling the rate of cardiovascular risk recording and the early detection of high cardiovascular risk. This proposed new QOF indicator would appear suited to incorporation within the sort of electronic system used in Bradford.
IND 1	Individual- Retired GP and carer	3rd consultation question How does primary care address weight management for people with severe mental illness The two recent National audits of Schizophrenia confirmed rates of monitoring of weight or BMI in only about 50% of people with schizophrenia. Although this large audit was done through the 'lens' of community mental health services the poor monitoring observed reflect on a combined failure of both primary and secondary care. Particularly disappointing was that even in those patients who had established CVD or diabetes the rates of monitoring were hardly any better – and this reflects particularly on primary care, who one would assume were responsible for managing the physical co-morbidity. This makes me suspect that primary care currently does not address weight management systematically for this population. However practice nurses in particular could have a potentially valuable role here with appropriate training. Moreover there is increasing evidence that health promotion approaches can help this population sufficient for NICE to issue a quality standard (Standard 7) on the importance of providing smoking cessation, nutrition and physical activity programmes (NICE QS80, 2015)

CONFIDENTIAL

Indicator ID.	Stakeholder Organisation	Comment
IND 1	Individual- Retired GP and carer	4th consultation question Should there be explicit areas of care which should be a requirement in care planning in primary care for people with severe mental illness A strong 'yes' for primary care to be explicitly involved in care planning in two situations: • Primary care as sole provider of care: The Reilly et al paper quoted above suggests that primary care is not only involved in shared care with secondary care, but for at least a third of those with severe mental illness is the sole provider of care. Thus for that group of people it is essential that primary care is involved explicitly in care planning – there is no-one else. • Shared care arrangements: primary care would normally be expected to take lead responsibility for managing physical health in the shared care arrangements for the two-thirds who do stay in contact with secondary care: ie after the initial twelve month phase following initial diagnosis and treatment (usually) with antipsychotic medication
IND 1	Whalebridge Practice, Swindon and QOF Database Website	Whilst the identification of CVD risk factors in patients with severe mental health problems is of commendable principle it is not clear whether there are appropriate and evidence based interventions available. The argument that severe mental health problems is a risk factor in itself is made in the consultation document and is persuasive. However the indicator relates only to the documentation of this rather than the treatment. An indicator about appropriate intervention may be more valuable and credible.
IND 1	Joint response from: Mind, Rethink Mental Illness, Centre for Mental Health, Mental Health Foundation, Mental Health Network and Royal College of Psychiatrists	Do stakeholders think this indicator is more or less likely to improve cardiovascular health in people with severe mental illness compared with the physical health indicators currently included on the NICE menu of indicators? We welcome proposed indicator QOF IND 1, especially in light of other physical health indicators for severe mental illness being retired in 2014/15. However we do have some concerns about the proposal. Firstly, we would question the rationale of specifying an age range of 25-84 in this indicator. While we

CONFIDENTIAL

Indicator ID.	Stakeholder Organisation	Comment
		recognise this is a wider age range than in previous QOF menus, it is unclear why there needs to be any range specified. Incidence of schizophrenia in males actually peaks between the ages of 10 and 25 for example. The NICE guideline for psychosis and schizophrenia (CG178), which is one of the supporting guidelines for this indicator, covers people aged 18 and over. The current national Commissioning for Quality and Innovation (CQUIN) payment for improving the physical health of people affected by mental illness also does not specify a 25+ age range. Weight gain associated with antipsychotic medication starts in the very early stages of taking medication, irrespective of age. However, as earlier onset is linked to a more severe disease course (for example in schizophrenia) it is reasonable to expect that people developing serious mental illness before the age of 25 will require larger doses of antipsychotic medication, meaning that the effect on their cardiovascular health will be magnified. It is therefore crucial that cardiovascular risks are being monitored from the start, including in people under 25. We would therefore recommend that this indicator instead applied to everyone on the practice register for people with schizophrenia, bipolar affective disorder and other psychoses (MH001). Secondly, it is unclear from the consultation what the risk assessment will consist of and whether it will replace any existing QOF indicators. We would recommend that the indicator explicitly lists the measurements to be taken, based on recommendation 1.3.6.4 in the NICE guideline on psychosis and schizophrenia (CG178). In order to improve cardiovascular health, it is important that any concerns raised through the risk assessment are acted upon. This is a crucial element of the CQUIN in secondary care and should be mirrored in any primary care intervention to improve cardiovascular health. The wording of the CQUIN is below: 'The results recorded in the patient's notes/care plan/discharge documentation as appropriate, together with a record of associated interventions according to NICE guidelines or onward referral to another clinician for assessment, diagnosis, and treatment eg smoking cessation programme, lifestyle advice and medication review.' The Lester Positive Cardiometabolic Health Resource sets out a clear framework for intervention for

CONFIDENTIAL

Indicator ID.	Stakeholder Organisation	Comment
		cardiovascular risk factors and could serve as a basis for the further development of this indicator. How does primary care currently deal with the specific needs of people with severe mental illness in relation to smoking cessation? 42% of all of the tobacco in England is smoked by people with mental illness, Research suggests that although people affected by mental illness are as motivated to stop smoking as the general population, they are less likely to be offered smoking cessation interventions than the general public. The interventions that work in the general population, also work in this group but may be required at a more intensive level and for a longer period of time. Monitoring is also necessary as reduced nicotine consumption can affect the metabolism of antipsychotic medication. As with the comments above, the key is ensuring that action is taken once smoking status is recorded under SMOKD02 and evidence-based interventions are offered to people, as outlined in NICE (PH45) and NICE PH48). Do stakeholder consider there to be any specific areas of care which should be an explicit requirement of care planning for all people with severe mental illness? The current list of care plan elements under MH002 in the QOF menu does not make explicit mention of physical health needs. While this is probably covered under the first section 'health status and social care needs', it might be helpful to mention it specifically, especially as it is singled out for inclusion in NICE CG178, recommendation 1.3.3.4. It would also help reinforce many of the other indicators in the QOF menu around cardiovascular risk, alcohol use and screenings.
IND 1	British Geriatrics Society	With the new indicator, it is more likely to improve CV health
IND 1	British Medical Association	We would support in principle the use of an overall CVD assessment rather than the current indicators, on the proviso that the components of that risk assessment are determined by the clinician. Some indicators, particularly lipids, are stable over many years and annual repetition might dissuade some patients from attending, as phlebotomy, and to a certain degree measurement of BMI, can be disliked by some patients. We would not support the decrease in age to 25 for annual assessment. It is important that this group

CONFIDENTIAL

Indicator ID.	Stakeholder Organisation	Comment
		receive lifestyle advise and support but the majority of them will have 10 years risks well below the intervention levels and so the quantifying of this on an annual basis will not alter their management, and reduce time available for more important tasks, such as smoking or dietary advise which should be provided independently of any specific cardiovascular risk. Reducing the time available to 12 months will be counter-productive. These patients have high DNA rates and if one were to miss an annual review late in the qof year there will be no incentive to chase that patient up to ensure prompt review, as the payment will already be lost even if they come after 13 months. It should be noted that many severely schizophrenic patients are under the care of a consultant or are in-patients (some in secure units). Assessing CVD risk may be difficult with this group.
IND 1	RCGP	The evidence that they have poor cardiovascular health is established. In answer to the first question we don't think that a specific indicator will add very much to the cardiovascular health of this group. GPs lack evidence based interventions and resources to help all patients deal with problems of weight, and we would expect that this may be more challenging with this group than others. However there is a concern that GPs will focus on cardiovascular risk to the detriment of discussing patients' mental health (because it is easier to manage in a mechanistic way). What, if they have no increased risk, is the rationale that it has to be repeated annually? Care planning and understanding the patient's priorities and expectations is key here. The specific and explicit requirement that we should be being asked to deal with for this group is trying our hardest to enable them to enjoy life more, not to enable it to continue unhappily. Feedback from the RCGP Overdiagnosis Group These patients should be considered for sexual health-contraception, sexually acquired infections, unwanted pregnancy, immunisation HPV/Rubella, screening for Chlamydia and help with psychosexual problems as they are vulnerable. (PS) Risk assessment does not equate to service provision to tackle increased risks, which may not be as readily accessible to people with severe mental illness compared to other people. Weight management

CONFIDENTIAL

Indicator ID.	Stakeholder Organisation	Comment
		services are not uniformly available in different localities and currently severe mental illness would be a probable exclusion criteria for bariatric surgery. Meanwhile, comprehensive support through a tier 3 obesity service is not widely available and the embryonic services that are developing may not have the capacity to help patients with more diverse and specialised needs. These issues would need consideration if this indicator is to avoid highlighting a gap in the ability of those with severe mental illness to access appropriate lifestyle support. (RP)
IND 1	Yorkshire and Humber Commissioning Support Unit	Would this indicator exclude patients who already have a diagnosis of CVD?
IND 1	Yorkshire and Humber Commissioning Support Unit	Would a separate indicator for recording blood pressure still be required if this indicator is implemented (given that BP is a key element of the CVD risk score)?
IND 1	Action on Smoking and Health (ASH)	It is surprising that with reference to CVD risk there is no mention of smoking in the indicator rationale, given that smoking is a major contributory factor. Furthermore, there are particularly high levels of smoking among people with mental health disorders. (Source: Smoking and mental health. Royal College of Physicians/Royal College of Psychiatrists, 2013) In answer to: Do stakeholders consider there to be any specific areas of care which should be an explicit requirement of care planning in primary care for all people with severe mental illness? In view of smoking causing the bulk of health inequality in mental health patients every smoker with a mental illness diagnosis should be regularly offered or referred to specialist cessation support and treatment. It is our understanding that many GPs are unaware of the best ways of managing smokers with severe mental health problems and have misconceptions about the use of treatments. Therefore, all primary health care staff should be trained in and understand how to deliver brief cessation advice so that smokers with mental health problems will be encouraged to access the required support and treatment to stop smoking. It also requires good quality, easily accessible specialist advisors trained to treat mental health

CONFIDENTIAL

Indicator ID.	Stakeholder Organisation	Comment
		patients.
IND 1	Royal College of Nursing	Question: Do stakeholders think this indicator is more or less likely to improve cardiovascular health in people with severe mental illness compared with the physical health check indicators currently included on the NICE menu of indicators? Our staff and members consider that people with severe mental health problems may need more time and different approaches to feel able to improve their risk. It would be helpful if Clinical Commissioning Groups put in formal arrangements around this QOF indicator and the role of community mental health service providers in helping to meet the indicator.
IND 1	Royal College of Nursing	Question: How does primary care currently deal with the specific needs of people with severe mental illness in relation to smoking cessation? Our staff and members feel that this will require engagement with community service providers as attendance at the GP surgery may not be the appropriate area for signposting of the promotion of smoking cessation for this group of patients.
IND 1	Royal College of Nursing	Question: Do stakeholders consider there to be any specific areas of care which should be an explicit requirement of care planning in primary care for all people with severe mental illness? Our staff and members consider that there are medicines management issues for pharmacology aimed at physical health in people with severe mental illness. This area would benefit from explicit care planning.
IND 1	Lundbeck	Lundbeck strongly supports the inclusion of IND 1 in the QOF. We have submitted detailed comments on QOF IND 1 separately, alongside our alliance partners Otsuka, for consideration.
IND 1	Institute of Primary Care & Health Sciences/ Arthritis Research UK Primary Care Centre, Keele University	Absolutely support this – evidence-base convincing. Tools for risk assessment available. Needs to be combined with action (ie risk assessment on its own is not enough) – smoking cessation support, advice about weight/activity/diet. And there is an evidence-base to support such intervention
IND 1	PHE Learning Disabilities Observatory	The same issue is also relevant to people with LD who form a similar number in the population. We would suggest there should be a similar indicator for people with LD.

CONFIDENTIAL

Indicator ID.	Stakeholder Organisation	Comment
IND 1	Lundbeck / Otsuka (joint response)	The percentage of patients aged between 25 and 84 years with schizophrenia, bipolar affective disorder and other psychoses who have had a CVD risk assessment performed in the preceding 12 months. The Alliance strongly supports the inclusion of this indicator in the QOF. We believe that, alongside the publication of the recently revised NICE guideline and quality standard on schizophrenia and psychosis, its inclusion is more likely to improve the cardiovascular health in people with severe mental illness. However, we would suggest that: • The age banding is removed as there is no evidence to support not undertaking a risk assessment in all adults with schizophrenia, particular those receiving antipsychotic medication • The indicator is amended to promote the use of the Lester Tool which is increasingly being used within mental health services by professionals and service users • Consideration is given to consolidating the existing QOF indicators and ensuring that this indicator has adequate QOF points attached to it to achieve real change The Government's No health without mental health highlighted that people with serious mental illness have significantly worse physical health outcomes than the rest of the population, and called for this to be addressed as a priority . The Schizophrenia Commission report found that, for example, people with the condition are three times more likely to die from cancer than the general population. Prevalence of type 2 diabetes is also two to three times higher for people with schizophrenia. In addition, people with severe mental illness are twice as likely to die from heart disease as the general population. Currently, significant unjustified variation exists in terms of physical health monitoring of people with schizophrenia and psychosis. The first National Audit of Schizophrenia (NAS1) raised major concerns regarding the poor physical health of people with schizophrenia, highlighting that many people are not getting the assessments they need to detect and treat physical health problems. Similarly, a recent survey conducted by Lundbeck, Otsuka and SANE found that around half (51 per cent, n=49) of respondents stated that they were dissatisfied with the support they, or the person they cared for/their family member,

Indicator ID.	Stakeholder Organisation	Comment
		received from their doctor in monitoring their physical health. In the second National Schizophrenia Audit (NAS2) only 33 per cent of people with schizophrenia had their smoking, elevated body mass index (BMI), blood glucose control, blood lipids and blood pressure monitored. This is an increase from 29 per cent compared to NAS1, but highlights the considerable ground that secondary care and primary care services need to make up to reach an acceptable provision of care. Furthermore, even monitoring something as basic as a service user's BMI was only recorded for 52 per cent in NAS2, and 51 per cent in NAS1. Most worryingly, even when health is identified as poor, the provision of interventions to tackle this is can often be found wanting. For example, in NAS2 only 36 per cent of service users with evidence of impaired control of blood glucose (suggesting diabetes or a pre-diabetic state) had evidence of an intervention taking place to tackle this. This was 53 per cent in NAS1. Indeed, as can be seen from the below table, across a range of physical health indicators comparing results from NAS1 and NAS2 there have been only a limited number of improvements made eg monitoring of lipids. As above, however, there are indicators which have actually declined. Monitoring of physical health risk factors NAS2 (%) NAS1 (%) Monitoring of five risk factors (family history excluded) 33 29 Monitoring of smoking 89 88 Monitoring of BMI 52 51 Range across trusts for monitoring of BMI 5 – 92 27 – 87 Monitoring of glucose control 57 50 Range across trusts for monitoring of glucose control 16 – 99 25 – 83

Indicator ID.	Stakeholder Organisation	Comment
		Monitoring of lipids 57 47 Monitoring of blood pressure 61 56 Monitoring of five risk factors in those with established cardiovascular disease 37 37 Monitoring of alcohol consumption 70 69 Intervention offered for identified physical health risks Intervention for smoking 59 57 Intervention for BMI > or = 25kg/m2 71 76 Intervention for abnormal glucose control 36 53 Intervention for elevated blood pressure 25 25 Intervention for alcohol misuse 74 72 As such, the above highlights that inclusion of this QOF indicator is extremely timely, but it is vital that this indicator supports wider developments including the recently revised NICE guideline and quality standard for schizophrenia and psychosis and also does not unnecessarily exclude people with severe mental health conditions based on age.
IND 1	Lundbeck / Otsuka (joint response)	The care and treatment course of people with schizophrenia and psychosis varies considerably, however, antipsychotic medication remains the cornerstone of treatment and this treatment can often have side effects, including weight gain. This is just one of the many reasons why people with schizophrenia are at risk of CVD, and although age is a factor in developing complications, all people with severe mental health conditions should be monitored regularly. With this in mind, we believe it is inappropriate to put an age band on the indicator. After a first episode or relapse a person with schizophrenia will often be under the care of secondary mental health services, with primary care services taking over based on agreed local timeframes once a person has begun their recovery. But this can happen before the age of 25 because schizophrenia is most often diagnosed between the ages of 15 and 35. As no rationale has been given for including this age band, it is unclear exactly what is trying to be achieved with its inclusion. Existing QOF indicators related to mental health do not include this age band and although Education, Health and Care Plans run up to 25, we see no reason why this should impact on

CONFIDENTIAL

Indicator ID.	Stakeholder Organisation	Comment
		this indicator. If its inclusion is to align with the use of QRISK2 tool, as will be discussed below, we believe this is inappropriate.
IND 1	Lundbeck / Otsuka (joint response)	Linked to the above, it is vital in this indicator that it is clear exactly what CVD risk factors are being assessed. In the recently published schizophrenia and psychosis quality standard, in relation to assessing physical health, it highlights that: Adults with psychosis or schizophrenia should have a regular health check (at least once a year) that includes taking weight, waist, pulse and blood pressure measurements and blood tests. This checks for problems such as weight gain, diabetes, and heart, lung and breathing problems that are common in adults with psychosis or schizophrenia and often related to treatment. The results should be shared between their GP surgery and mental health team. In addition to this, the current CCG OIS includes an indicator (C1.12) which aims to reduce premature death in people with severe mental illness by ensuring that people have a recorded set of physical checks in the preceding 12 months, including: • 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 • smoking status This indicator has not yet specified how the risk assessment should be undertaken, but it is vital that it is in line with existing processes and ongoing developments. A simple way of doing this is to develop this indicator so that it promotes the use of the Lester Tool.

CONFIDENTIAL

Indicator ID.	Stakeholder Organisation	Comment
		The Lester Positive Cardiometabolic Health Resource (Lester Tool) provides practitioners with a simple assessment and intervention framework to protect the cardiovascular and metabolic health of patients with severe mental illness receiving antipsychotic medication. Its clear message to not just screen, but to intervene should be encouraged and it covers all of the above essential checks. Although no tool is currently specified for this indicator, we note that other indicators in this consultation promote the use of the QRISK2 tool to assess CVD. In our view, the indicator should specify the use of the Lester Tool over the use of a generic CVD risk assessment tool. Furthermore, an additional benefit of removing the age banding from this indicator, as highlighted above, would be to make a distinction between the QRISK2 tool and the Lester Tool. Finally, by promoting the use of the Lester Tool across primary care, it should also help with integration as the tool is being widely promoted across secondary mental health services. It would also, we suspect, help align current care planning processes in place amongst the many secondary mental health providers.
IND 1	Lundbeck / Otsuka (joint response)	Amending this indicator to remove the age banding and promote the use of the Lester Tool would have implications on the existing QOF indicators. As shown above, the problems with physical health monitoring are widespread and systemic. Current arrangements need to be simplified to ensure that it is as easy as possible to comply and act on any identified risk factors. There are existing QOF indicators for mental health which look specifically at elements of this CVD risk assessment eg blood glucose and alcohol consumption, but not the whole process. By amending the indicator to focus on promoting the Lester Tool and, as such, cover all of the essential checks - similar to the proposed bundled indicator for diabetes - it would help to streamline the QOF process. This would also allow for a consolidation of not only the indicators, but also their associated QOF points. The more points attributed to this indicator in order to encourage compliance, the greater the impact this indicator could have.

CONFIDENTIAL

Indicator ID.	Stakeholder Organisation	Comment
IND 1	Lundbeck / Otsuka (joint response)	Despite the increasing uncertainly about the future of the QOF, it is vital that indicators remain relevant, build upon the steps being taken to achieve parity of esteem and confront the biggest challenges facing people with severe mental health conditions. With the NHS Five Year Forward View advocating the creation of multispecialty community providers which could include GPs and mental health services/trusts, ensuring a unified CVD assessment process for people with severe mental issue will also help to aid the integration of services. Removing the age band and promoting existing tools used in current practice should help in this regard and we would be keen to help promote this work in any way possible.
IND 1	East Sussex Public health	As well as making an assessment and recording the findings, the standard and consistency of advice given following the CVD risk assessment will be key to improving cardiovascular health, including the consideration of NICE guidance on behaviour change Do stakeholders consider there to be any specific areas of care which should be an explicit requirement of care planning in primary care for all people with severe mental illness? Consideration of the impact of ant-psychotic medication on CVD prevention activity

CONFIDENTIAL

Appendix B: Equality impact assessment for IND-1 (severe mental illness)

Table 1

Protected characteristics
Age
Disability
Gender reassignment
Pregnancy and maternity
Race
Religion or belief
Sex
a) Sexual orientation
b) Other characteristics
Socio-economic status c) Depending on policy or other context, this may cover factors such as social exclusion and deprivation associated with geographical areas or inequalities or variations associated with other geographical distinctions (e.g. the North/South divide, urban versus rural).
Marital status (including civil partnership)
Other categories Other groups in the population experience poor health because of circumstances often affected by, but going beyond, sharing a protected characteristic or socioeconomic status. Whether such groups are identifiable depends on the guidance topic and the evidence. The following are examples of groups covered in NICE guidance: • Refugees and asylum seekers • Migrant workers • Looked after children • Homeless people.

CONFIDENTIAL

Indicator Equality Impact Assessment form
Development stage: Consultation
Topic: Severe mental illness

1. Have relevant equality issues been identified during this stage of development? • Please state briefly any relevant issues identified and the plans to tackle them during development
No equality issues have been identified during this stage of the process.
2. Have relevant bodies and stakeholders with an interest in equality been consulted • Have comments highlighting potential for discrimination or advancing equality been considered?
Yes – stakeholders from all 4 UK countries were encouraged to comment on the potential new indicators as part of the NICE consultation and a wide group of relevant groups and organisations were contacted. Please refer to appendix A of the 'process report for indicators in development' for a full list of stakeholders consulted directly via email.
3. Have any population groups, treatments or settings been excluded at this stage in the process? Are these exclusions legal and justified? • Are the reasons for justifying any exclusion legitimate?
This indicators only cover people with schizophrenia, psychosis and bipolar disorder which is consistent with the current QOF mental health domain. Although comments received by stakeholders did suggest this indicator should be applied to all ages.it currently excludes people below the age of 25 and over the age of 84 years. This is because the recommended risk assessment tool (QRISK2) for people with SMI is restricted to this age group. A stakeholder also suggested during consultation that this indicator may be beneficial to people diagnosed with conditions other than an SMI e.g. learning difficulties.
4. Do any of the indicators make it impossible or unreasonably difficult in practice for a specific group to access a test or intervention? • Does access to the intervention depend on membership of a specific group? • Does a test discriminate unlawfully against a group? • Do people with disabilities find it impossible or unreasonably difficult to receive an intervention?
No – comments from the consultation exercise do not suggest that the indicators will make it impossible or unreasonably difficult in practice for a specific group to access a test or intervention.
5. Do the indicators advance equality? • Please state if the indicator as described will advance equalities of opportunity, for example by making access more likely for certain groups, by tailoring the service to certain groups, or by making reasonable adjustments for people with disabilities?
There were no consultation comments to suggest that the indicators would necessarily advance equalities in terms of people with protected characteristics or other relevant characteristics.