NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

INDICATOR DEVELOPMENT PROGRAMME

Briefing paper

Topic area: Physical health of people with severe mental illness (SMI)

Potential output: Recommendation for indicator development

Date of Indicator Advisory Committee meeting: 1&2 June 2015

Contents

Introduction

At the December 2014 QOF Advisory Committee meeting, NICE presented a paper that provided a review of the updated NICE guidelines for people with severe mental illness (SMI) - schizophrenia, psychosis and bipolar disorder collectively referred to within the QOF mental health register as SMI.

- psychosis and schizophrenia in children and young people: Recognition and management (CG155)
- psychosis and schizophrenia in adults: treatment and management (CG178)
- bipolar disorder: the assessment and management of bipolar disorder in adults, children and young people in primary care and secondary care (CG185)

During the discussion in December 2014 specific questions were asked around smoking cessation and weight management for people with SMI.

The Committee asked the NICE team to:

- review the current QOF indicators for smoking cessation to identify whether there should be discrete indicators of smoking status recording and cessation advice for this population
- investigate the potential to develop indicators for weight management for people with SMI.

The QOF Advisory Committee requested this topic be brought back for discussion in June 2015 in the context of both primary and secondary care. In addition NICE has also recently published a quality standard for psychosis and schizophrenia in adults (QS80) which can be also used as a source for any potential indicators:

NICE quality standard for psychosis and schizophrenia in adults (QS80)

Overview of bipolar and schizophrenia

Definitions

Bipolar disorder: is a mental illness characterised by episodes of depressed mood and episodes of elated mood (mania or hypomania). For many people the predominant experience is of low mood. In its more severe forms, bipolar disorder is associated with significant impairment of personal and social functioning.

Schizophrenia: is a major psychiatric disorder, or cluster of disorders, characterised by psychotic symptoms that alter a person's perception, thoughts, and behaviour. It is characterised by 'positive symptoms' such as auditory hallucinations, bizarre delusions, and disrupted speech ('thought disorder') and by 'negative symptoms' such as social withdrawal, demotivation, self-neglect, and the appearance of flat affect. Subtle cognitive impairment is also a feature.

Incidence, prevalence and evidence of variation by age, sex and ethnicity

Psychosis is a common mental illness, with schizophrenia being the most common form of psychotic disorder. Schizophrenia has a point prevalence averaging around 0.45% and a lifetime expectancy of 0.7%, although there is considerable variation in different areas and a higher risk in urban environments (CG178, Full Guideline).

- A review of the incidence of psychosis and schizophrenia in England between 1950 and 2009 (Kirkbride et al 2012) found a pooled incidence of 31.7 per 100,000 for psychosis and 15 per 100,000 for schizophrenia.

- Men under the age of 45 were found to have twice the rate of schizophrenia than women. The rate of schizophrenia was found to be significantly higher in black Caribbean and black African migrants and their

descendants, compared with the baseline population (CG178, Full Guideline).

Community-based epidemiological studies report lifetime prevalence rates of bipolar disorder in European studies to vary from 0.1% to 2.4%. Bipolar disorder has a fairly early age of onset, with the first episode usually occurring before the age of 30 years. There is evidence of an increased incidence of the disorder in people from black and minority ethnic groups (CG185, Full Guideline).

Morbidity and mortality

- People with schizophrenia will on average die 14.6 years earlier, bipolar 10.1 years and patients with schizoaffective disorder die 8 years earlier than the general population (NHS England, 2014).

- People diagnosed with schizophrenia have a shorter life expectancy than the general population but with similar causes of premature death including CVD, respiratory illness and cancer.

Smoking amongst people with SMI

People with schizophrenia in the UK are far more likely to smoke than the rest of the population, data indicates that 73% of people with schizophrenia smoke, compared to 22% of the general population (Brown et al, 2010).

There is also long standing evidence that premature death and smoking related diseases, such as respiratory disorders and heart disease, are more common among people with serious mental illness who smoke than in the general population of smokers (McDonald, 2000)

Policy Context

Based on a review of the following policy documents and national initiatives across the UK, the NICE Indicators Team has identified that review of the indicators for SMI on the NICE menu for QOF is a priority at the current time:

- NHS England (2014) Factsheet: Smoking cessation for people with a serious mental illness (SMI)
- Primary Care Mental Health (2014) Primary Care Guidance on Smoking and Mental Disorders
- Royal College of Physicians (2013) Smoking and Mental Health
- National Obesity Observatory (2011) Obesity and mental health
- Rethink Mental Illness (2013) Lethal discrimination: why people with mental illness are dying needlessly and what needs to change
- Joint Commissioning Panel for Mental Health (2011) Practical mental health commissioning: a framework for local authority and NHS commissioners of mental health and wellbeing services

Smoking cessation in people with SMI – current QOF indicators

The QOF currently contains a number of indicators to help people stop smoking (table 1). These indicators 'bundle together[1]' a number of conditions including SMI.

Table 1 smoking indicators currently in the QOF

Indicator ID	Indicator wording
SMOK002 (NM38)	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 (NM39)	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

Although the overall achievement rate for these indicators is high at circa 95% it has been suggested that this overall high performance may 'hide' lesser performance for the people with SMI.

The published literature concerning this potential differential performance for the SMI group is conflicting:

- Using data from the UK Taggar et al (2012) reported lower rates of smoking recording and advice for people with SMI compared to other groups such as people with CVD
- Conversely other studies (UK and international) report no significant difference in the provision of smoking cessation advice for people with SMI and for people without SMI (Mitchell et al, 2015; Hippisley-Cox et al, 2007)

[1] Bundled together in this case refers to a number of conditions being measured under the same indicator.

It should also be noted that NICE guidance (PH48) highlights that people using mental health services should be provided with intensive support to assist in their smoking cessation.

Possible changes to the current QOF smoking indicators – focus on SMI

The Committee is asked to consider the potential benefits of creating discrete QOF smoking indicators that focuses solely on people with SMI rather than the current approach of ‘bundling’ people with SMI alongside other conditions.

Weight management in people with SMI

People with SMI are at higher risk of developing CVD etc. In addition for some the prescribing of antipsychotic medications causes further weight gain. There are currently no indicators in the QOF or the OIS around monitoring weight and weight management interventions for this population. Evidence suggests children and young people appear more vulnerable than adults to side effects of antipsychotic medication including weight gain (NICE CG155).

The physical health problems associated with SMI also means there is an increased risk of type 2 diabetes. A European study screening people with schizophrenia who were not known to have diabetes, discovered 10% had type 2 diabetes and 38% were at high risk of type 2 diabetes; this population's average age was only 38 years (Manu et al, 2012).

Despite there currently being no current QOF or CCG OIS indicators for weight management in people with SMI there are number of NICE guideline recommendations that could be used to underpin an indicator (see table 2).

Table 2 NICE guideline recommendations that could be used to underpin indicators for weight management for people with SMI

Psychosis and schizophrenia in adults: treatment and management (CG178)	
NICE CG178 1.1.3.1	People with psychosis or schizophrenia, especially those taking antipsychotics, should be offered a combined healthy eating and physical activity programme by their mental healthcare provider
NICE CG178 1.1.3.2	If a person has rapid or excessive weight gain, abnormal lipid levels or problems with blood glucose management, offer interventions in line with relevant NICE guidance
NICE CG178 1.5.3.3 (**primary care**)	Identify people with psychosis or schizophrenia who have high blood pressure, have abnormal lipid levels, are obese or at risk of obesity, have diabetes or are at risk of diabetes (as indicated by abnormal blood glucose levels), or are physically inactive, at the earliest opportunity following relevant NICE guidance: (see Lipid modification CG181], Preventing type 2 diabetes PH38, Obesity CG43], Hypertension, CG127], Prevention of cardiovascular disease, PH25 and Physical activity, PH44.
Psychosis and schizophrenia in children and young people: Recognition and management (CG155)	
NICE CG155 1.7.3 **(primary care**)	Identify children and young people with psychosis or schizophrenia who smoke or who have high blood pressure, raised lipid levels or increased waist measurement at the earliest opportunity and monitor for the emergence of cardiovascular disease and diabetes
Bipolar disorder: the assessment and management of bipolar disorder in adults, children and young people in primary and secondary care (CG185)	
NICE CG185 1.8.2 (**secondary care**)	People with bipolar disorder, especially those taking antipsychotics and long-term medication, should be offered a combined healthy eating and physical activity programme by their mental healthcare provider
NICE CG185 1.8.3 (**secondary care**)	If a person has rapid or excessive weight gain, abnormal lipid levels or problems with blood glucose management, take into account the effects of medication, mental state, other physical health and lifestyle factors in the development of these problems and offer interventions in line with the NICE guidance on obesity, lipid modification or preventing type 2 diabetes
NICE CG185 1.8.4 (**secondary care**)	Routinely monitor weight and cardiovascular and metabolic indicators of morbidity in people with bipolar disorder. These should be audited in the annual team report.

New indicators for weight management for people with SMI

The Committee is asked to review the NICE recommendations in table 2 with the aim of suggesting potential areas for future indicator development. This could be for the QOF or the CCG OIS.

Key considerations for the Committee

The following key considerations summarise the main points made in the briefing paper and should be used by the Committee in their discussions.

- Should people with SMI be removed from the current indicators SMOK002 (NM38) and SMOK005 (NM39) which addresses smoking across a number of conditions, and covered as a separate group within a new discrete set of QOF indicators?

- The committee is asked to propose and discuss potential future indicators to support weight management in people with SMI.

References

Brown S, Kim M, Mitchell C, Inskip H. Twenty-five year mortality of a community cohort with schizophrenia. *The British Journal of Psychiatry*. 2010;196:116-21

Hippisley-Cox, J. Parker, C. Coupland, C. Vinogradodova, Y. Inequalities in the primary care of patients with coronary heart disease and serious mental health problems: a cross-sectional study.*Heart BMJ* 2007 93 1256-1262

Kirkbride JB, Errazuriz A, Croudace TJ, Morgan C, Jackson D, Boydell J, et al. Incidence of schizophrenia and other psychoses in England, 1950-2009: a systematic review and meta-analyses. *PLoS One*. 2012;7.

Manu P, Correll CU, van Winkel R, Wampers M, De Hert M. Prediabetes in patients treated with antipsychotic drugs. *Journal of Clinical Psychiatry*. 2012; 73 (4) 460-6.

McDonald C. Cigarette smoking in patients with schizophrenia. BJP 2000; 176: 596-7

Mitchell, A. Vancampfort, D. De Hert, M. Stubbs, B. Do people with mental illness receive adequate smoking cessation advice? A systematic review and meta-analysis. *General Hospital Psychiatry.* 2015 37 14-23

NHS England. Commissioning for Quality and Innovation (CQUIN) 2014/15 Guidance. 2014

NICE PH48 Smoking cessation in secondary care: acute, maternity and mental health services. Available online: https://www.nice.org.uk/guidance/ph48

Taggar, J. Coleman, T. Lewis, S and Szatkowski, L. The impact of the Quality and Outcomes Framework (QOF) on the recording of smoking targets in primary care medical records: cross-sectional analyses from The Health Improvement Network (THIN) database. *BMC Public Health*. 2012. 12-329